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Problems of Social Security

First Item on the Agenda

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PREFACE

The title of this item of the agenda is as vast as the multitude of problems, social, economic, political, financial and administrative, national and international, that are involved in the realisation of the broadest conception of social security. Nevertheless, it is well chosen as a subject for discussion by a Preparatory Asiatic Regional Conference. Social security, whatever the precise meaning assigned to it, is certainly something greatly desired by peoples everywhere. From a discussion in which every participant can explain his own approach to the subject, it should be possible to distil some conclusions which specify the problems of social security for practical purposes and recommend a programme of further study and action.

The Report prepared by the Office on this item ought clearly to contain a working definition of social security, and for that the pertinent Recommendations of the Philadelphia Session of the International Labour Conference supply the indications. It is also clear that a summary of those Recommendations and likewise of relevant provisions of the Recommendations, adopted at the Philadelphia and Paris sessions, on social policy in non-metropolitan territories ought, for convenience, to be included. It is obvious that a survey, incomplete though it must be, ought to be given of the present law and practice of social security in the countries concerned; thanks to the prompt action of the Chinese and Indian branches, important sources for the survey have been added to those already available in Montreal.

It should be added that the Report was communicated in proof to the Governments of Asiatic countries which will be represented at the New Delhi Conference. A mission of officials of the Office also visited several of these countries with a view to having the information contained in the draft verified and amplified through discussion with

local officials, in accordance with a proposal made by the Director-General, and approved by the Governing Body, of the International Labour Office. The observations made by the local officials have been taken into account as far as possible in preparing the Report for publication, and the valuable assistance received from them in making the facts and figures mentioned in the Report accurate and up to date is hereby gratefully acknowledged.

It seemed that, for the Office, the reasonable approach to the subject would be to ask, first, whether and how far the main structural principles of the above-mentioned Recommendations are applicable to the situation and prospects of the Asiatic countries and constitute a desirable, if distant, objective for them. The alternatives of social insurance and social assistance have been summarily examined. The problem of social security for the agricultural classes, who constitute a very large majority of the population of Asia, has been all too briefly considered. While any practical suggestions that the Conference can make must be thoroughly pursued, the conclusion would seem inescapable that, in the matter of cash benefits, the established techniques of social insurance or social assistance cannot yet, or for a long time to come, be applied to the great mass of small cultivators. On the other hand, the Office does believe that ordered, if slow, progress can be made in the building up of a medical care service for the agricultural population.

The remainder of the Report is intended to prepare the way for the adoption of a social insurance programme for wage earners, especially in urban areas, and of a medical care programme. Here the Office has ventured to describe the main features of the programme it would recommend. The presentation of arguments and suggestions is necessarily incomplete, but if some of the statements therefore appear dogmatic, they should evoke reasoned challenge from the Conference, and the issues will be clarified. [1]

[1] For a survey of the evolution of the law and practice of social insurance and social assistance up to 1941, see I.L.O : *Approaches to Social Security*, Studies and Reports, Series M, No. 18 (Montreal, 1942). For an explanation of the Income Security and Medical Care Recommendations, see : International Labour Conference, 26th Session, Philadelphia, 1944, Report IV (1) : *Social Security : Principles.*

In the belief that only by means of social insurance can income security be provided for wage earners, two possible ways of improving upon the existing laws and institutions are examined: the one way is that of the gradual or, as it were, natural evolution of independent branches of social insurance; the other, for which the Office does not disguise its preference, is that of the development of social insurance as a whole in conformity with a preconceived plan. It would seem that the choice between these alternatives made by the Preparatory Conference will largely determine the treatment of social security by a subsequent Regional Conference.

The proposed programme of medical care looks towards the gradual development and extension of a public medical care service, freely available to those who need it, whether they dwell in urban or rural areas and whether they are workers or dependants. Such a service doubtless requires special fiscal resources to finance it; a service confined to insured persons by or for whom contributions have been paid should be contemplated, if at all, only as a transitional measure.

It may be noted that a Conference, convened by the Indian Council of World Affairs to discuss economic, social and cultural problems common to all Asiatic countries, and attended by delegates from over 25 of these countries, was held in New Delhi in March-April 1947; and that the introduction of social security schemes and the expansion of medical education and of the training of nurses and midwives are among the recommendations made in the report on social services adopted by that Conference. The Asian Relations Conference also recommended the formulation of fair labour standards, with the standards laid down in I.L.O. Conventions as a basic minimum.

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CHAPTER I

SOCIAL SECURITY AS AN OBJECTIVE OF SOCIAL POLICY

Social security is a dynamic conception that is influencing social policy as a whole and likewise economic policy: in its widest meaning it seems to coincide with freedom from want. For the present purpose, however, it is taken to mean freedom from want as assured by the benefits in cash and in kind of social insurance or social assistance schemes covering the principal risks which deprive workers and their dependants of their means of subsistence.

The use of this term emphasises the objective rather than the method of attaining it, and implies that the benefits should be reasonably sufficient. Cash benefits will not remove anxiety from the persons for whom they are destined unless the scale and duration of the payments are in reasonable relation to the need. Benefits in kind, chiefly medical care and placement in suitable employment, are necessary complements to the cash benefits payable in case of illness or unemployment; but they also help independently to raise the standard of living. It further implies that the promised benefits will be duly available in the contingencies for which they are intended, and so indirectly a criterion is set for the organisation of the benefit services.

If people could individually cover the risks which threaten their means of subsistence, social security services would be superfluous. But such contingencies as illness, death and unemployment may occur with disastrous effects at any time, and they cannot be provided against by persons in isolation. The risks must be transferred from the individual to a community to which he belongs. The community must possess the financial strength necessary to enable it to honour

all claims that experienced foresight can expect to be presented. Its membership must be numerous enough to keep the average risk fairly stable. The permanence of the community must be assured. These conditions are fulfilled only by social insurance schemes applying to a large number of workers in a wide variety of occupations and by social assistance schemes the solvency of which is guaranteed by the State or other powerful political unit.

Social security is being sought as an objective to be attained for society as a whole by society as a whole. Ideally, risks are to be as widely shared as possible, and the fortunate in every sphere are to help the unfortunate. Whereas in private insurance risks expected to be equal are arranged in independent groups, in social insurance there is a measure of intentional grouping of unequal risks, while in social assistance there is no differentiation of the members of the community according to risk.

The creation of social security services brings great advantages to a society, raising its moral value, relieving directly the physical and mental distress which afflicts a vast proportion of the people, helping to reduce the causes of those evils, and cementing the structure of the society itself.

Especially where the method of social insurance is applied, the social security service promotes the effective conversion of the mass of the population into a genuine society. For the first time, perhaps, the manual workers are called upon to participate in the active reciprocal process of paying contributions and receiving benefits, learning thereby economic responsibility and the advantage of mutual aid. Employers likewise, as contributors to a social insurance scheme, become more fully aware of their interest in the well-being of their workers. Also the State, in establishing the scheme, guaranteeing its correct administration and perhaps subsidising it, is revealed as never before in the role of promoter of personal welfare.

Health is the primordial condition for prosperity, and the combination of incapacity benefit with comprehensive medical care is calculated to increase the working capacity of the population.

Social security services remove important causes of the fluctuation of incomes. A regular income has a higher marginal utility than the same income which is unpredictably irregular. A smaller volume of savings need be kept idle. The more regular income of the insured population is reflected in the greater regularity of consumption and so of the operation of industry.

The many advantages of social security services, however, must not lead us to believe that they constitute a panacea for social ills, because this is not true. These services are concerned with the contingencies involving interruption of earnings and with illness. They assume that the insured person ordinarily receives at least a living wage and enjoys good health. Consequently the creation of social security services is not a primary, but only a secondary, objective of social policy. Introduced prematurely in countries where the insured population is not properly fed, clothed and housed, where the environment is insanitary, social security services have proved disappointing. Resources that could have been spent on promoting the general fitness of the population have been diverted to treating—naturally with only temporary success—diseases that could have been prevented.

But here again the argument must not be pushed to an extreme conclusion. Thus it would be absurd not to introduce sickness benefit and medical care until all preventable disease has been eliminated, or unemployment insurance until none but frictional unemployment subsists. A common-sense judgment is necessary. The risks to be borne by the service must be of manageable proportions, and the charges for covering them must not weigh upon individuals already at the poverty line. In a practical programme, designed to raise the national standard of living, primary needs are doubtless to be met first, but meanwhile a beginning may be made in the satisfaction of the secondary needs of those whose situation is already tolerable and who are ready to co-operate for their own betterment.

CHAPTER II

THE INTERNATIONAL LABOUR CONFERENCE AND SOCIAL SECURITY

During the decade 1925 to 1934 the International Labour Conference adopted a series of Conventions laying down international standards for workmen's compensation, sickness insurance, pension insurance, and unemployment provision. It dealt in 1925 and 1935 with the benefit rights of workers who change their country of residence, in two Conventions, concerning workmen's compensation and pension insurance respectively. Special Conventions were adopted in 1936 on shipowners' liability to sick and injured seamen and on seamen's sickness insurance, but these have been superseded, not in form, but in practice, by the more comprehensive Conventions of 1946 on the social security and pensions of seafarers. Maternity insurance is mentioned in the Childbirth Convention (No. 3), 1919.[1]

The Conference had necessarily to treat social insurance branch by branch, because that was the way social insurance had developed before World War II. The Conventions lay down the standards which could obtain the requisite majority of votes in the Conference, and which, in fact, had already been reached by the chief industrial countries in Europe. The circumstances of their adoption precluded any strict adherence, in successive Conventions, to uniform principles proper to a unitary conception of social insurance. Nevertheless, the Conventions do constitute a social insurance code,

[1] For an analysis and the texts of the Conventions and Recommendations adopted on social insurance up to 1933, see I.L.O.: *The International Labour Organisation and Social Insurance*, Studies and Reports, Series M, No. 12, (Geneva, 1936). For the texts of the Conventions and Recommendations adopted on social insurance up to 1936, see *The International Labour Code, 1939* (Montreal, 1941). Book VI, and Title III of Book I.

the parts of which are consistent with each other in their broad provisions. A Member which ratified them individually as opportunity offered, could, if it worked on a long-term plan, find itself in possession of a complete and coherent social insurance system.

It is in the matter of scope—the workers and employers to whom they apply—that the Conventions show the greatest harmony. The general rule is that all persons employed in industry, commerce, and agriculture are protected.

The main risks that threaten the workers' livelihood are covered: personal injury by accident or disease connected with employment, sickness, maternity, invalidity, old age, death, and unemployment. On the cardinal question of minimum rates of benefit, no standards could be agreed upon for insertion in the Conventions, though more or less precise indications could be included in Recommendations.

The principle of the joint contribution of insured person and employer is laid down as regards both sickness and pension insurance, and the State is required to subsidise pension insurance. The financing of workmen's compensation is left unregulated, but it is clear that the different benefits of workmen's compensation can be furnished by the employer, accident insurance, sickness insurance, or invalidity insurance, as may be appropriate.

The Unemployment Provision Convention (No. 44), 1934, can be implemented by means of voluntary insurance or compulsory insurance, with or without a complementary assistance scheme.

Either in Conventions or in Recommendations, two principles of organisation are advocated: that employers and insured persons should participate in the administration; and that special tribunals should be set up for the speedy settlement of disputes.

The desirability of unifying and rationalising social insurance had often been discussed in Europe, but, in the case of the older systems, the reformers and theorists had never been able to make their views prevail against the practical difficulties of changing radically a huge administration. In some of the later systems, however, a marked degree of uni-

fication was attained. In 1938 New Zealand produced a new model of social security legislation, which protects the entire population with a complete range of subsistence benefits, including children's allowances, and with free medical care; this is financed chiefly by a special, universal, income tax. It may have exerted a certain influence on the Beveridge Plan, although Lord Beveridge had advocated the unification of social insurance 20 years ago. What is important is that the ideas, launched in New Zealand and the United Kingdom, of universal scope, comprehensive cash benefits, and a comprehensive medical care service have captured the imagination and reason of statesmen and peoples everywhere, and have found expression in social security plans that have appeared in a series of other countries, for example, Australia, Brazil, Canada, France, and the United States.

Thus it was that, in 1944, at its Philadelphia Session, the International Labour Conference was able to adopt by large majorities a pair of Recommendations, on income security and medical care, which reduced these ideas to the form of guiding principles. At the same session a Recommendation was adopted on employment services and, since an employment service is a necessary accompaniment—and, indeed, precursor—of unemployment insurance, a brief reference is made to this Recommendation here, although the development of employment services is treated in another report in connection with general problems of unemployment and underemployment.[1]

The three subjects of the Recommendations are the three necessary forms of benefit of a social security system: cash benefits in case of inability to work or to obtain work; and the services designed to prevent or remedy the need for cash benefit—medical care, and placement in suitable employment. Each of these benefits to the individual presupposes the existence of a corresponding national policy serving the community as such: the control of the cost of living; the creation of a healthy environment, and the promotion of

[1] See Report II: *Labour Policy in General, including the Enforcement of Labour Measures*, Chapter II.

full employment. The benefits to individuals and the community services are geared together in a single mechanism which cannot operate effectively if any of its parts is missing or ill-proportioned.

Under social security schemes as now operating or under consideration, cash benefits and medical care are, in the American countries, furnished on an insurance basis, supplemented in some cases by an assistance system; but in the British Commonwealth there is a marked tendency to make medical care a free service available to the public at large, while in Australia and New Zealand the right to cash benefit and the obligation to pay the social security contribution are disjoined. An employment service, on the other hand, where it exists, is always available freely to everyone who seeks its aid.

The Income Security Recommendation (No. 67) recognises, by its form and content, that in the treatment of the problem of involuntary loss of income the primary consideration should be the need of the person concerned and his family, and not the particular cause of the loss, as for example, sickness or unemployment, nor even the value of the contributions he has paid. The Recommendation looks towards the establishment of a single system of compulsory insurance under which all employed and self-employed persons would be insured for benefits at least sufficient for subsistence in case of inability to work (including old age), inability to obtain remunerative work, and death, in consideration of contributions paid by them and on their behalf by employers and the State. Definitions are given of the contingencies in which cash benefits should be granted sickness, maternity, invalidity, old age, death of breadwinner, unemployment, and employment injury. The insurance system should be administered in consultation with organisations of workers, employers, and other categories of contributors. Provision is made for a subsidiary assistance system for the maintenance of dependent groups, especially children, who lack sufficient means of support. The broad guiding principles of the Recommendation are amplified by detailed suggestions as to the manner in which they might be

applied. It is suggested, for example, that the creation of a unified social insurance system providing basic benefits should not preclude the operation of special schemes of insurance affording supplementary benefits for certain occupational groups.

The Recommendation (No. 69) concerning medical care is concerned with methods of organising a complete medical care service designed ultimately to embrace the entire population. It includes many suggestions for alternative methods of organisation, to be selected according to the degree of development of the service and the varying nature of the problems to be solved. Medical care, both curative and preventive, should be as complete as possible and made available through an organisation that ensures the greatest possible economy and efficacy by the pooling of knowledge, staff, and equipment, and that, subject to reasonable limitation, allows the patient to choose his doctor. It may be furnished by a social insurance service covering both the contributors and their dependants or by a free public service; in either case the beneficiaries and the medical and allied professions should be represented in the administration. As a matter of course, all persons in receipt of cash benefits under a social insurance system should be entitled to medical care. Close co-ordination should be established between the medical care service and the general health services which exist to safeguard the health of the whole community or of certain groups particularly threatened.

The Recommendation (No. 72) on national employment services develops the principle already adopted in a Convention of 1919—that each country should establish a system of free public employment agencies under the control of a central authority. During the war the mobilisation of manpower in the countries concerned had engendered a new conception of the role of the employment service, which may be characterised as a constructive approach to its task. The functions of the service, in consequence, should not be limited to placing workers in suitable employment and assisting employers to fill vacancies properly in co-operation with unemployment insurance, but should include the collection of

every kind of information which is needed for the execution of a full employment policy and the planning of the location of industry.

The Income Security and Medical Care Recommendations explicitly recognise in their preambles that differences in national conditions will affect the length of the period within which it will be possible to carry out the principles recommended. For the Asiatic countries, with their vast agricultural populations, and without the many years of social insurance experience that the European countries have behind them, the period of fulfilment will naturally be long; nevertheless, so far as their wage earners are concerned, it may be possible to make rapid progress.

The fact that the Conference, at its Paris Session (1945), felt justified in including in its Recommendation (No. 74) on social policy in non-metropolitan territories substantial provisions for the development of social security services is most encouraging. In Eastern Asia, there are certain similarities of basic economic and social conditions between sovereign States and non-metropolitan territories, and what is deemed possible for the latter may be assumed *a fortiori* to be so for the former.

The Paris Recommendation lays particular stress on the introduction of workmen's compensation, and envisages its inclusion in a social insurance scheme; for this branch the standards laid down in the Workmen's Compensation Conventions, 1925, are considered to be applicable. As regards social insurance generally, the Recommendation states (Annex, Article 12):

1. It shall be an aim of policy, in areas where substantial numbers of the workers normally earn their living by wage earning, to introduce compulsory insurance for the protection of wage earners and their dependants in cases of sickness and maternity, old age, death of the breadwinner and unemployment. As soon as the necessary conditions for the operation of such insurance are present, arrangements to that end shall be inaugurated.

2. It shall be an aim of policy to provide, through compulsory sickness and maternity insurance, medical care for injured persons and their dependants, in so far as such care is not already provided as a free public service.

The Recommendation also refers particularly to the desirability of establishing " systems of retirement allowances, including provisions for contributions by the Government or employers or both as well as by workers " (Annex, Article 5).

CHAPTER III

SOCIAL SECURITY PROVISIONS IN CERTAIN ASIATIC COUNTRIES

In this Chapter has been assembled the information at present available to the Office on social security provisions in China, India, Siam, Burma, Ceylon, Indo-China, Indonesia, Malaya, Singapore, and the Philippines.[1] The survey includes legislation and plans relating to social insurance proper, workmen's compensation legislation, maternity benefit legislation, and the sickness benefits, provident funds, and welfare funds of individual works or establishments.[2] A brief note is added on the comprehensive Social Relief and Assistance Act of China. For most of the countries only the workmen's compensation and maternity benefit legislation is available, but for some of them it has been possible to give an account of provisions voluntarily instituted by employers.

Social Insurance Legislation

Salt Miners' Insurance in China

A social insurance scheme for salt miners in Northern Szechuan was approved by the Executive Yuan in June 1943. By December 1946 some 40,000 workers in 10 establishments were insured against employment injury, sickness,

[1] The terms Indonesia and Malaya as used in this Report refer, unless otherwise specified, to the territory of the former Netherlands Indies and to the Malayan Union, respectively. The latter was created on 1 April 1946 and consists of the former Straits Settlements, with the exception of the present colony of Singapore, and the former Federated and Unfederated Malay States; where the information given refers to the period before 1 April 1946, the term Malaya refers to the territory of the Malayan Union and Singapore together.

[2] Medical care services are dealt with more particularly in Chapter VI.

old age and death (including the death of the worker's parents and wife). Persons employed in salt mining who are over the age of 16 are compulsorily insured under the scheme, unless they are temporary workers.

The scheme is administered by a local insurance society, which is under the direct jurisdiction of the Ministry of Social Affairs and the supervision of the National Salt Administration. The business of this society is conducted by a board of five directors, namely, a representative of the local salt administration as chairman, two representatives of the mine owners, and two representatives of the salt miners.

The cost of the scheme is met by employers' and employees' monthly contributions and a subsidy from the local salt administration and the Ministry of Social Affairs. The worker's contribution is fixed at 1 per cent. of his monthly remuneration, and the employer pays an equal amount in respect of each worker.

Medical care is provided at the clinics of the insurance society or at the local hospitals. Employment injury benefit is payable from the date of the injury, but sickness benefit is subject to a three-day waiting period. The rate in both cases is equal to the worker's average standard wage, and the benefit is payable till recovery but not for more than 90 days within a year. On the marriage of an insured person, a benefit equal to 20 per cent. of his average annual standard wage is granted without qualifying period; on his death, a similar sum is payable to meet his funeral expenses, and on the death of one of his parents or his wife, the same amount is granted.

Lump-sum benefits, based on annual remuneration, are also payable in respect of old age and death. The basic old age benefit, granted at age 60, is subject to a minimum qualifying period of 5 years and ranges from 120 per cent. of annual remuneration up to a maximum of 200 per cent. where the beneficiary has been insured for at least 10 years. There is a qualifying period for survivors' benefit, which is computed as follows: 40 per cent. of annual remuneration if the worker was employed less than one year; 80 per

cent. for 1-2 years' employment; 120 per cent. for 2-3 years' employment: 160 per cent. for 3-5 years' employment and 200 per cent. for over 5 years' employment.

If a worker who has been insured for more than two years and has received no benefit under the scheme, leaves his employment or is dismissed by the mine, he is entitled to a refund of his part of the contributions.

Workmen's Compensation

Workmen's compensation laws are in operation in all the territories covered by this survey. The Indian Act of 1923 appears to be the first example of this type of legislation in these territories, and has been the model for the legislation of Ceylon and Malaya. In Burma it is in force without the amendments effected after 1938, but the revision of the Act is contemplated for the purpose of widening its scope and improving its provisions. The Philippine Act dates from 1927. The Chinese Factory Act, which contains workmen's compensation provisions, was consolidated in 1932. In Ceylon, Indo-China, Indonesia and Malaya, workmen's compensation laws were introduced between 1934 and 1939.

Scope

The scope of the laws is determined by the definition of the status of a " workman " and by the definition of the undertaking in which the " workman " must be employed in order to be protected by the law.

All employed persons are deemed to be " workmen ", except those whose remuneration exceeds a prescribed amount and those whose employment is of a casual nature and not for the employer's trade or business (India[1], Ceylon, Malaya, Philippines).

In Singapore, only persons engaged in certain trades specified in the schedule attached to the Workmen's Compensation Ordinance are considered to be workmen, but it is proposed to adjust the schedule to make it more comprehensive.

[1] In India, clerical workers in certain specified undertakings are excluded.

The Philippine law applies to employment for the purposes of any business by an employer whose gross income is at least 20,000 pesos a year.

The Chinese provisions, forming, as they do, a chapter of the Factory Act, apply only to factories covered by that Act, namely, those which employ 30 or more persons and use power-operated machinery.

In Indo-China, there are at present in force different workmen's compensation schemes, applicable to different categories of workers.[1] In the first place, the French Act of 1898 on workmen's compensation was extended to cover Europeans and persons treated on the same footing, by a Decree of 9 September 1934. Secondly, a Decree of 30 December 1936 governing the conditions of employment of Asiatic labour (free labour, as distinct from contract labour, which is covered by another scheme) had laid down the general principle of the right to compensation in respect of any industrial accident to workers employed in industrial, commercial or agricultural undertakings, provided that the resulting incapacity for work lasted more than four days. The detailed methods of administration of the Decree were to be laid down in Orders. Thus, an Order of 31 January 1944 defines these methods with respect to accidents to persons employed in industrial (excluding handicraft) undertakings and commercial undertakings; undertakings in certain areas may be exempted, or the application of the regulations may be limited in such areas to undertakings of a size and character justifying their inclusion; after consultation of the occupational associations concerned, the regulations may be extended to certain types of agricultural and forestry undertakings. In both these schemes, aliens are covered only on condition that persons of French nationality or under French protection are entitled to similar treatment in the alien's country of origin. Thirdly, in the absence of the extension of the 1936 regulations to agricultural workers, contract labour on the plantations continues to be covered by the more

[1] The reform of social legislation is being studied and some of the draft Bills provide for the abolition of racial discrimination in this matter.

limited workmen's compensation provisions contained in the Order of 25 October 1927, as amended by that of 21 September 1935. Lastly, the free labour employed in agricultural undertakings in Cochin-China is entitled, in the event of sickness or accident directly caused by the employment, to the medical care prescribed by the Order of 10 August 1942 concerning the health and safety of such labour.

In New Caledonia, the regulations for the protection of indigenous labour contained in an Order of 11 February 1943, and those for the protection of immigrant labour (to which the contract system has ceased to apply) contained in Orders of 18 July and 12 November 1945 and the appended model agreements, establish the workmen's compensation rights of both agricultural and industrial (mainly mining) workers.

The other laws contain lists of the classes of undertakings to which they apply. Most of the lists include factories using power-operated machinery, mines, railways, shipping, and construction. Factories not using such machinery may be covered if a minimum number of persons are employed: 10-20 in India, 25 in Ceylon and Malaya.

In India, Burma, and Malaya, the laws apply to plantations on which at least 25 persons are employed; in Ceylon, plantations are included if they employ 10 persons. In Indonesia and the Philippines, agricultural workers are protected by the workmen's compensation law only if they are using mechanical implements. Forestry is included in the scope of the Indian, Ceylon, and Indonesian laws.

Risks Covered

In China, the risks covered are defined as "sickness or injury in the performance of duty". The Philippine law likewise covers both sickness and injury directly caused by the employment.

In India, Burma, Ceylon, and Malaya, compensation is payable in respect of accidents arising out of and in the course of employment, and in respect of specified occupational diseases. Common to all four lists are: anthrax,

and poisoning by lead, phosphorus, mercury, and arsenic. In Burma, Ceylon, and Malaya, the list includes also benzene poisoning and chrome ulceration. The Indian list further adds compressed-air illness, lead tetra-ethyl poisoning, nitrous fume poisoning, pathological manifestations due to radio-active substances or X-rays, and primary epithelio-matous cancer; and the Ceylon list, compressed-air illness and accidents in occupations which involve the handling of radium or X-ray apparatus or contact with radio-active substances.

In Indonesia, the law covers only accidents connected with work. The same general rule applies in Indo-China and New Caledonia, although in certain cases of sickness not directly caused by the employment, the employer is required to provide medical care.

Benefits

Medical Benefit.

The laws of China, Indo-China, New Caledonia, Indonesia, and the Philippines require the employer to provide or pay for medical care. The maximum duration of the benefit is six months in China, one year in Indonesia, and apparently four years in the Philippines. In Indo-China and New Caledonia, the law does not specify any period. In Ceylon, compensation is reduced if the worker refuses medical care offered by the employer and thereby aggravates the effect of the injury.

Temporary Incapacity Benefit.

Benefit is payable in respect of incapacity for work from the day the incapacity begins or the day after in China and Indonesia. In India, Burma, Ceylon, and Malaya, there is a waiting period of seven days, while in the Philippines, compensation is payable only if the incapacity lasts for 14 days, and in that case, payment is antedated to the eighth day. In Indo-China, the waiting period is four days in the schemes for Europeans and free Asiatic labour; for contract labour, wages continue to be paid without interruption in the event of an industrial accident; for free agricultural labour, only medical care is provided.

The rates of temporary incapacity benefit vary from 50 per cent. of wages in Burma, French Establishments in India, Indo-China (European and free Asiatic labour), and Malaya[1] to 60 per cent. in the Philippines, 66 2|3 per cent. in China, and 80 per cent. in Indonesia. The rate is reduced to 50 per cent. in China after six months of incapacity, and in Indonesia after one month. In India, the rate varies from full wages in the case of persons earning 10 rupees or less to 1|5 of wages for those earning 300 rupees a month. In Ceylon, it varies from actual wages in the case of persons earning 10 rupees or less to 1|3 of wages for those earning 300 rupees a month.

Permanent Incapacity Benefit.

In China, India, Burma, Ceylon, and Malaya, benefit in the case of permanent incapacity for work takes the form of a lump sum. The Philippine law provides for weekly payments during a limited period. In Indonesia, a pension is payable. In Indo-China, the scheme for Europeans provides for a pension according to a graduated scale, while that for free Asiatic labour pays compensation in the form of a lump sum varying with the degree of incapacity but not exceeding the annual wage in the event of total incapacity: in addition, repatriation is provided where necessary and the injured worker is entitled to artificial limbs and appliances.

In China, the lump sum varies between 1 and 3 years' wages. In India, Ceylon, and Malaya, it is fixed as follows in the case of total incapacity: from 18½ months' wages to 42 months' wages in Ceylon, according to earnings; from 18½ to 70 months' wages in India; and at 42 months' wages or $M.4,300[2] in Malaya. A proportionately smaller amount is paid if the incapacity is partial; benefit already paid in respect of temporary incapacity is deducted from the lump sum. In Burma, the compensation for total disablement varies with the monthly wage, from 700 rupees for a wage of 10 rupees or less to 5,600 rupees for a wage of over 200 rupees.

[1] In Malaya, a half-monthly payment of $M.30 or a sum equal to 25 per cent. of wages, whichever is the less, is made.

[2] Whichever is the less.

A pension varying with the degree of incapacity is paid in the French Establishments in India.

The Philippine law provides for weekly benefit in the case of permanent incapacity, to continue for a maximum of 208 weeks, including any period during which temporary incapacity benefit was paid. The rate of the permanent incapacity benefit is 60 per cent. of wages if the incapacity is total, and half the wage reduction if the incapacity is partial.

The pension payable under the Indonesian law is proportionate to the degree of incapacity, and is apparently payable without limit of time.

Survivors' Benefit.

Provision is made for the payment of a special funeral benefit in China, Indo-China, Indonesia, and the Philippines. The survivors to whom a benefit is paid in the case of death generally comprise the widow (or widows in some cases), incapacitated widower, minor children, and (except in Indonesia) grandchildren, parents and grandparents, and brothers and sisters. The Ceylon definition is very wide and includes illegitimate children.

In China, the employer is required to pay two years' wages to the legal heirs. A lump sum ranging from 13 1|3 to 50 months' wages in India and Ceylon and amounting to 30 months' wages[1] in Malaya is distributed among the dependants by the competent workmen's compensation commissioner at his discretion. In Burma, the sum varies from 500 rupees where the monthly wage of the deceased is 10 rupees or less to 4,000 rupees where it is over 200 rupees In Indo-China, the lump sum paid to survivors under the scheme for Asiatic labour is equivalent to one year's wages. In Indonesia, a lump sum of 300 days' wages for the widow and 200 days' wages for each of not more than two children is payable. In the French Establishments in India, a lump sum is paid varying with wages from 20 to 50 times the monthly wage.

In the Philippines, the survivors, according to their

[1] Or $M.3,200, whichever is the less.

number and their kinship with the deceased, are entitled to benefit at the rate of 25 per cent. to 60 per cent. of wages for 208 weeks.

Security for Payment

The employer is liable for the entire cost of compensation. He is not required by any of the laws to insure his liability. However, in Indonesian law, there is a provision enabling the Government to set up a fund to which all employers must contribute, except those who have sufficient financial strength to secure the due discharge of their liability. In Ceylon, a large number of workers are insured with licensed insurance companies, and the Government has its own fund for the workers in its commercialised undertakings. In Indo-China, the employer is authorised to transfer part of his liability to the mutual aid society, if any, for the staff of his undertaking, provided he contributes to its fund. He may also institute proceedings against third parties.

Administration

Claims for compensation not settled by agreement between the parties are decided by special workmen's compensation commissioners, or by commissioners of labour acting as workmen's compensation commissioners, in India, Burma, Ceylon, and the Malayan Union. In Singapore, claims which are not settled by agreement between the parties, or with the assistance of the Labour Department, are referred to the Commissioner for Workmen's Compensation. In these cases, the Commissioner for Labour has the right to appear before the Commissioner for Workmen's Compensation, on behalf of the injured workmen or his dependants. In difficult cases free legal advice and assistance is given to the claimant by the Government. In Indo-China, the court of first instance or the magistrate has authority to fix the amount of compensation, but the parties may subsequently agree on some other form of compensation.

Statistics

For India, Burma, Ceylon, Indonesia, and Malaya, some statistics are available on the operation of their workmen's compensation laws.

The Indian statistics for 1942 and 1943 are not complete, since figures for the province of Bombay and for railway, postal and telegraph employees are wanting, and since not all employers are required to submit returns of compensation cases, and not all who are so required do submit returns.

NUMBER OF CASES OF ACCIDENT AND AMOUNT OF COMPENSATION PAID DURING 1942 AND 1943 IN INDIA (EXCEPT BOMBAY)

Result of accident	No. of cases of accident		Amount of compensation paid (1,000 rupees)	
	1942	1943	1942	1943
Death	828	1,123	745	972
Permanent disablement ..	1,568	2,436	448	801
Temporary disablement ..	28,693	41,267	315	510
Total ..	31,089	44,826	1,508	2,283

A report on the working of the Indian Workmen's Compensation Act in Burma in 1939 furnishes the following summary table:

COMPENSATION PAYMENTS REPORTED BY EMPLOYERS IN BURMA, 1939

Establishments and workmen covered; Result of accident	Railways and tramways	Factories	Mines	Others	Total
Establishments:					
Number	4	1,020	411	153	1,588
Percentage insured	—	13	9	20	13
Workmen:					
Number	17,057	90,220	26,453	20,611	154,341
Percentage insured	—	31	43	65	38
Death:					
Cases	5	19	20	8	52
Cost .. rupees	2,970	21,170	16,093	9,460	49,693
Permanent disablement:					
Cases	7	96	15	73	191
Cost .. rupees	1,491	23,770	2,589	23,375	51,225
Temporary disablement:					
Cases	253	1,160	536	1,007	2,956
Cost .. rupees	3,855	13,397	5,337	10,575	33,164
Total per 100 workmen employed:					
Cases	1·51	1·41	2·16	5·28	2·07
Cost .. rupees	49	65	91	211	87

The Report of the Ceylon Commission on Social Services, published in February 1947, gives the following averages for the five-year period 1939-1943:

	No.	Compensation paid
		Rupees
Accidents reported	7,271	—
Claims paid :		
Fatal	77	60,210
Permanent injury	201	80,097
Temporary injury	5,841	85,109
Agreements registered ..	844	—

It may be added that over a period of 10 years the number of cases in which compensation could not be recovered was only 15.

For Indonesia, statistics of the accidents reported under the workmen's compensation law have been published for 1940. The number of workers in the branches of industry covered by the law was 661,171; the number of accidents was 3,567, or 54 per 10,000 workers. In 3,211 of the total number of cases, the worker recovered; 190 were cases of disablement; and in 166 cases the accident was fatal.

Owing to wartime conditions, the most recent figures available for Malaya relate to 1938. They show a total of 9,049 cases of accident reported, including 232 fatal accidents, and 147 applications for compensation. The number of cases settled by agreement during the year was 493, and of those disposed of in open court 165 (157 in favour of the claimant and 8 in favour of the employer).

Ratification of Workmen's Compensation Conventions

The principal instrument, which is the Workmen's Compensation (Accidents) Convention (No. 17), 1925, has not been ratified or applied in any of the territories considered. The main defects of the existing legislation are the following: in all the territories, the exclusion of a great part of agricultural labour, and many urban workers, from the protection of the laws: the absence of compulsory insurance or other means of ensuring the due payment of compensation; in most of the laws, the award of compensation in cases of permanent incapacity and death in the form of a lump sum instead of periodical payments corresponding to the duration of the beneficiaries' needs; in several of

the laws, the lack of any provision at all for medical care.

The Workmen's Compensation (Occupational Diseases) Convention (No. 18), 1925, has been ratified by India, and the ratification is binding also on Burma. Most of the additional diseases specified in the Workmen's Compensation (Occupational Diseases) Convention (Revised) (No. 42), 1934, are also covered by the Indian and Burmese Acts. The Chinese and Philippine laws, covering as they do all injury and sickness due to employment, could easily be amended by the addition of a provision that the diseases listed in the revised Convention shall, if contracted by persons in the corresponding employments specified therein, give rise to the payment of compensation, and could so be brought into conformity with this Convention. In Ceylon, most of the diseases specified in the Conventions are covered by existing legislation and steps are being taken for the inclusion of the remainder.

The Equality of Treatment (Workmen's Compensation) Convention (No. 19), 1925, has been ratified by China and India, and is applied also in Burma. In Ceylon, the Workmen's Compensation Act does not discriminate against foreign workers, and arrangements have been made with some Indian provinces and States and with Malaya for the payment of compensation to dependants residing in those territories. The other laws considered here are apparently also in conformity with this Convention, in that they contain no provisions discriminating against foreign workers.

Maternity Benefits

In all the territories, except Burma and Indonesia, covered by this survey, legislation has been enacted requiring employers to pay a cash benefit to women workers during abstention from work before and after childbirth. The following paragraphs summarise the provisions relating to the workers covered, the qualifying period of employment, and the amount and duration of the benefit.[1]

[1] An analysis of legislation concerning maternity protection, both in self-governing and in non self-governing territories, is given in I.L.O : *The Law and Women's Work*, Studies and Reports, Series I, No. 4 (Geneva, 1939), Chapter III.

In China, the benefit is limited to women factory workers[1] ; in India, benefit is paid to women in factories and mines, and in Assam also to women on plantations; in Ceylon, it is paid to women employed in shops, mines, factories, and estates where 10 or more persons are employed; and in Malaya and the Philippines, it seems that women workers generally are covered. In Indo-China, benefit is payable only in the case of Asiatic contract labour; in the case of free labour, women are entitled to maternity leave, but the employer is not under an obligation to continue the payment of their wages.

In order to be able to claim the benefit from her employer, the woman must have been employed in his undertaking for a prescribed minimum period of 6 or 9 months in India[2], Ceylon[3], and (for the right to full wages) China. No such condition, however, is laid down in the laws of Indo-China, Malaya, and the Philippines.

The cash benefit is equal to full wages in China, Indo-China and the Philippines. In most of the Indian provinces, the benefit is fixed at a uniform daily rate which seems intended to correspond to the average earnings of unskilled women workers. In Ceylon, the rate is fixed from time to time by regulation and is at present 1 rupee for each day of the 6 weeks of benefit.

The combined duration of benefit before and after childbirth is, in most laws, 8 weeks or 60 days, equally divided over the two periods. However, the total period is 2 months in Malaya, and 6 weeks in Ceylon (2 before and 4 after), while in the Philippines the benefit is payable only for one month following childbirth. In India, the underground work of women in mines is prohibited. The ban was lifted during the war as an emergency measure, but was reimposed with effect from 1 February 1946. During

[1] This provision of the Factories Act has not yet been put into force.

[2] The period is 150 days in Assam and Bengal; in most provinces it is 9 months.

[3] A 1946 amendment requires the woman to have worked not less than 150 days within the year preceding the date on which she notified the employer of her expected confinement.

the emergency period, the Mines Maternity Benefit (Amendment) Act, 1945, entitled women employed underground in mines to 16 weeks of benefit (10 before and 6 after).

The employer is required to furnish medical care, in addition to the cash benefit, on Malayan estates (subject to certain conditions, defined in the Labour Code) and in some Indian provinces. In Indonesia, there is a liability on employers generally in industry and agriculture to furnish medical care and food for women workers, and, while the woman is in hospital, food for her dependants. In Ceylon, the employer may obtain permission from the Commissioner of Labour to reduce the cash benefit to 4 rupees a week if he provides alternative benefits (hospitalisation, obstetrical attendance, and food). Women on plantations who are not entitled to maternity benefit receive sufficient food and lodging for one month at the expense of the employer.

Reports from the Indian provinces show that the legislation has not been uniformly applied. Women fail to file claims either because they are unaware of their rights to benefit or because they fear such an application may be followed by dismissal. In some cases women workers are unable to prove completion of the requisite period of service because their employers have not kept the proper records. For Ceylon it is stated that employers on estates have generally complied with the requirements of the law, but that the same degree of compliance has not been secured in mines, factories, and shops.

Statistics

Statistics for 1945 are available for four Indian provinces: Bombay, the Central Provinces and Berar, Madras, and the United Provinces. In Bombay, 728 of the 779 factories covered by the Maternity Benefit Act reported an average of 54,793 women employed daily, of whom 5,199 were paid maternity benefits, amounting to 212,598 rupees in all. In the Central Provinces, it was found that most of the textile mills paid maternity benefit at rates 50 per cent. higher than those prescribed by the Act, out of an average total of 5,195 women employed daily, 637 were paid a total of

21,185 rupees. In Madras, out of a total of 2,626 factories registered under the Factories Act, figures are available for 1,762. These employed an average total of 49,110 women per day, of whom 1,705 were paid benefits, amounting to 47,836 rupees. In the United Provinces, where 184 factories employing an average of 2,932 women per day were subject to the Act, 192 women out of an average total of 2,168 per day were paid benefits, amounting to 11,857 rupees.

The estates which pay contributions to the Immigration Fund in Ceylon report the granting of benefit in 1944 totalling 670,311 rupees in 34,366 cases; in 1945, ordinary benefits amounted to 583,010 rupees in 23,827 cases, and alternative benefits to 256,002 rupees in 11,552 cases.

Ratification of Convention

The Childbirth Convention (No. 3), 1919, has not been ratified by any of the countries included in this survey. The most serious want of conformity lies in the method of providing the benefits. The Convention requires that they should be "provided either out of public funds or by means of a system of insurance", whereas all the legislation in question makes the employer individually liable. The other defects are the lack of medical benefit—difficult to arrange by the employer individually—and the insufficiency of the period of cash benefit.

Social Insurance Plans

China

The chief measures planned for post-war social security in China relate to an employment service, social insurance, and public assistance. This is in accordance with the new Constitution of the country, which was promulgated on 1 January 1947 and comes into effect on 25 December 1947, and which in particular provides in Article 155 for the introduction of a State social insurance system. The proposed measures are designed to benefit persons in urgent need of social assistance and relief, and in the first place those who contributed to the war effort, including ex-servicemen, small farmers and tenant farmers, munitions

and communications workers, and Government employees and teachers.

As regards social insurance, a Preparatory Office of the Central Bureau of Social Insurance was approved in November 1946 by the Executive Yuan and was established in January 1947, under the Ministry of Social Affairs. The main functions of the Preparatory Office are: (1) to draw up regulations for the enforcement of the social insurance programme; (2) to secure foundation funds for the social insurance programme; (3) to devise an accounting system; (4) to institute a personnel system; (5) to establish social insurance societies; and (6) to make other necessary preparations.

The social insurance plans are of four types; (1) health insurance, covering sickness, disability, death, and maternity care; (2) industrial injuries insurance, covering accidents, injuries and death; (3) invalidity insurance; and (4) unemployment insurance.

In principle, a national compulsory system is proposed, under which all workers whose incomes do not exceed the prescribed limit are liable to insurance, except that under certain special conditions a person can be exempted.

The contribution payable by any insured citizen who is working for another for pay will vary according to his income, and his employer will be required to pay the same amount. Those working on their own account pay the full contribution; if necessary, the Government may grant a certain subsidy.

After the work of the Preparatory Office has been completed, a Central Social Insurance Office is to be established under the Ministry of Social Affairs. Branch offices or societies are to be set up in the various provinces and municipalities throughout the whole country or entrusted to some other local organisation, not of a commercial nature. Both the Central Office and the branch offices are to be organised along business lines. In setting up the system of social insurance, the question whether the occupational or the territorial classification, or both, should be adopted, is to be determined according to local circum-

Since social insurance is recognised as a State function under the Constitution, its funds are to be included in the national annual budget and paid from the National Treasury.

India

A Bill for a unified scheme of health and employment injury insurance for industrial workers was introduced in the Indian Legislative Assembly in November 1946. The question of health insurance had been under consideration during the preceding three years. In 1944, Professor B. P. Adarkar, at the instance of the Department of Labour, drew up a report on the subject[1] which contained a comprehensive survey of the more important systems of health insurance in operation for industrial workers and proposed a scheme especially designed to suit Indian conditions. The scheme was considered and commented upon by two officials of the International Labour Office who visited India early in 1945, in response to an invitation from the Government of India.

The Workmen's State Insurance Bill at present under discussion breaks new ground in the field of social insurance inasmuch as it proposes an integrated scheme embodying workmen's compensation and maternity benefit with health insurance. The scheme will at the outset apply to workers coming under the Factories Act, but it is proposed to extend it to other workers after experience has been gained and the administrative organisation set up. Persons employed solely in a clerical capacity or earning more than 400 rupees a month are excluded from the Bill.

The Bill covers the risks of sickness, employment injury, and maternity, and provides both medical care and cash benefits. Medical care will be given in case of sickness, injury or maternity to out-patients without a time limit so long as they continue to be in insurable employment and thereafter for not more than 3 months, or, if they qualify for cash benefit, for 6 months. In-patient treatment in a hospital or other institution or at the patient's home is

[1] B. P. ADARKAR: *Report on Health Insurance for Industrial Workers* (Simla, Government of India Press, 1944).

granted so long as the patient is entitled to sickness, employment injury, or maternity cash benefit. Cash benefit is payable in case of sickness at the rate of not more than 50 per cent. of average earnings in the previous 6 months, for a period not exceeding 8 weeks in any period of 12 months; to qualify for such benefit, the insured person must have completed at least 6 months of insurance and paid not less than 17 weekly contributions in the 6 months preceding the week in which he claims benefit or the week when he ceased to be employed; he retains his right to sickness benefit for 6 months if he was qualified at the time his employment came to an end (free insurance period).

Maternity benefit is paid at the rate of 12 annas a day for a period of 12 weeks (6 weeks before and 6 weeks after confinement), provided the beneficiary has not less than 26 weekly contributions to her credit within a specified 12-month period.

Periodical disablement benefit is granted without qualifying conditions in the event of employment injury, for the total duration of incapacity, whether total or partial, temporary or permanent; the rate of benefit for total incapacity is the same as in case of sickness, *i.e.*, 50 per cent. of wages, but is based on the average of the 12 months preceding the claim.

In case of death resulting from employment injury, but not otherwise, the widow (widows) of the deceased is (are) entitled to a pension at the rate of 3/5 of the disablement benefit for total incapacity, for life or until remarriage; legitimate children each receive 2/5 of that rate until they reach the age of 18 years (if a daughter, until remarriage). The total amount of survivors' benefit cannot, however, exceed the full rate of disablement benefit. If the deceased worker leaves no widow or children, the parents or grandparents and other male and female dependants under 18 years of age are entitled to benefit at rates determined by the competent workmen's compensation commissioner.

The administration of the scheme is entrusted to a Central Corporation, whose functions are performed by a Central Board comprising representatives of the Central and pro-

vincial Governments, employers, workers, and the medical profession. The Board also includes members elected by the Central Legislative Assembly. A Standing Committee of the Board acts as the Executive of the Board, and a Medical Benefit Council advises on matters relating to the administration of medical benefits. Medical care is provided by the provincial Governments, which administer the existing medical care services for the population. The standard of care and the details of its administration will be determined by agreement between the Corporation and the provincial Governments. The cost of the medical benefits is shared between the Governments and the Corporation. If the average incidence of sickness cash benefit in any province is in excess of the all-India average, the provincial Government will also bear such share of the cost of the excess incidence as may be agreed upon between the province and the Corporation. Workmen's State Insurance Courts will decide disputes and adjudicate all claims.

The scheme will be financed by contributions from employers and workers, the employers paying the major share in view of the fact that under the present system employment injury compensation and maternity benefits are at their exclusive charge. The Bill does not provide for a subsidy by the Central Government, but a grant equivalent to 2/3 of the cost of administration will probably be made by the Central Government for a period of five years. The funds of the scheme may also be used for the improvement of the welfare and health of industrial workers, rehabilitation, etc.

It is also proposed to revise the Workmen's Compensation Act so as to secure for workers not covered by the new Workmen's State Insurance scheme, periodical payments on the scale proposed under that scheme and a measure of medical care. As many categories of employers as possible will be required to join a compulsory accident insurance fund administered by a quasi-State corporation. The scope of the Act is to be extended to cover further classes of workmen, and new items, such as silicosis, will be added to the list of occupational diseases.

Finally, the Government proposes to introduce a Central Act giving women workers not covered by the new health insurance scheme the same rights as regards maternity benefit as those provided under that scheme.

Ceylon

The Ceylon Commission on Social Services, which was appointed in July 1944 to enquire into the adequacy of existing social services and the question of introducing social insurance, and published its report in February 1947, recommends the introduction of a social insurance scheme for all employed persons aged 16 to 60, covering the risks of sickness, maternity, and unemployment, coupled with a non-contributory social assistance scheme extending to the whole population and providing old-age pensions at 70 years (65 in the case of women), orphans' pensions, and pensions for the blind aged 45 or over, as well as children's allowances in respect of each child of school age (5-14 years) after the second.

This insurance scheme for employed persons would be completed by a contributory National Provident Fund, out of which capital and periodical payments would be made in the event of prolonged sickness or unemployment, marriage of a daughter, death of a dependant, premature death of the contributor or attainment of age 55. The provident scheme, financed by proportionate contributions of employers and insured persons, would provide the latter with a variety of alternative benefits, and, coupled with sickness and unemployment insurance, would take account of the particular conditions obtaining in Ceylon, such as the wide disparity of earnings, the low expectation of life, the need for saving in order to provide the State with capital, the frequent transfers from one employment to another, the custom of investing funds in land to secure an income in old age, the seasonal character of much of the employment, the need of immigrant labourers to return to their country on retirement, the part that many employers already contribute to provident funds, and so forth. Unemployment assistance for those who have not qualified for insurance benefit, improved workmen's compensation, and an extended residuary poor

relief service would supplement the social insurance and assistance scheme recommended for gradual implementation.

The proposed scheme provides for cash benefits only, the provision of medical care being left to the existing health services, which, in the opinion of the Commission, should be extended and improved. It is recommended to set up a Ministry of Labour and Social Welfare, a separate department of which would deal with social security. Only the National Provident Fund would be administered by an independent commission.

Close relations between the Ministry of Health and the Ministry of Labour and Social Welfare should be established, it is held, not only centrally but locally, through social welfare centres dealing with public health and the care of the sick, the indigent, and the unemployed. The combined sickness, unemployment, and provident fund insurance scheme for employed persons (including estate workers)—estimated at roughly 30 per cent. of the population—would be administered locally by a single social welfare officer with an office in the employment exchange.

The benefits proposed under the insurance scheme are: sickness benefit for 26 weeks at 2|3 of the salary or wage, with a maximum of 40 rupees a week; maternity benefit at full wages (maximum, 40 rupees) for 6 weeks ; funeral benefit of 50 rupees; unemployment benefit at 2|3 of wages (maximum, 10 rupees a week) for 13 weeks.

Sickness and maternity insurance and the National Provident Fund would be financed by employers and employees alone, unemployment insurance on a tripartite basis. The social assistance scheme would be wholly financed by the State. The total cost to public funds is estimated at 84 million rupees.

Contributions under the combined sickness, unemployment, and national provident fund scheme would be at the rate of 1 rupee a week per member and 5 per cent. of payroll, for the employer ; and 10, 20, 50 or 100 cents a week for employees with daily incomes of less than 75 cents, 75 cents to 1.49 rupees, 1.50-3.99 rupees, and 4 rupees or more, respectively, plus 5 per cent. of income, for insured persons.

Pensions from public funds would be at the rate of 5 rupees a month for old-age pensioners, subject to an income limit of 20 rupees a month; 5 rupees for orphans, subject to a family income limit of 40 rupees; and 20 rupees to all blind persons. Children's allowances also amount to 5 rupees a month where the family income does not exceed 100 rupees a month. Unemployment assistance benefit is at the same maximum rate as unemployment insurance benefit.

The Report of the Commission on Social Services also proposes to enlarge the scope of the existing workmen's compensation scheme so as to cover all employment under contracts of service, with the exception of out-workers, domestic servants, members of the employer's family, and employees whose wages exceed 300 rupees a month. Benefit would be paid in respect of the waiting period where incapacity continues for more than 4 weeks; insurance would be compulsory; and the procedure for recovering compensation would be simplified and other improvements made.

Works Benefit Schemes

Works Sickness Schemes

All the various territories no doubt possess some medical care facilities provided by the Government and available to the general population, and several of them have made it a legal obligation for the owners of plantations to provide medical care for their labourers. Such information as the Office has on these provisions is considered in Chapter VI.

But a number of industrial employers (including the State in that capacity) are known to have set up, on their own initiative, sickness schemes providing cash and medical benefits for their employees; details of 20 such schemes covering 130,000 workers have been published for India, and similar schemes are to be found in other territories.

The schemes are found only in large undertakings. In most of them the employer pays the entire cost, and where the employee is required to participate, his contribution is extremely small. Medical care is commonly furnished by medical practitioners and assistants appointed by the em-

ployer, and is available both to employees and to their dependants. It may be noted, however, that those employers in Colombo who supply medical care free of charge do not as a rule include their workers' dependants. The cash benefit is generally either full or half wages, the lower rate being usually combined with a longer benefit period. Thus full wages may be paid for one, two or three weeks as a maximum, whereas in cases where half wages are paid, the maximum period is usually three months. On the other hand, the schemes of two oil companies in India and of the Burma Oil Company, pay a lower rate of benefit for the first few days of sickness, and a higher rate for a further three months. Several of the schemes make the payment of cash benefit conditional on a qualifying period of one year's employment or on a waiting period of three to seven days of sickness.

Works Provident Funds in India

Some of the large undertakings in India have set up funds consisting of the employer's and employees' contributions, and from which invalidity, old-age and death benefits are paid. The establishment and maintenance of such provident funds on a sound basis is encouraged and controlled by certain tax exemptions, provided the rules of the fund satisfy specified conditions. The Provident Funds Act, 1925, as amended, applies to railway and Government provident funds, and the Indian Income Tax Act, 1922, as amended, to those company funds which are entitled to special treatment for income tax purposes. The Indian (tripartite) Labour Conference has recently given consideration to the desirability of benefit schemes of this type, and its Standing Committee has drawn up rules for a model provident fund, which, it has been suggested, might be circulated among employers.

Railway and Government Provident Funds.

The Provident Funds Act, 1925, as amended, lays down rules for the protection of the compulsory deposits and the repayment of sums standing to the credit of a subscriber,

with deductions therefrom where he has incurred liabilities to the Government or the railway administration, has been dismissed for any of a number of specified reasons or has resigned employment within five years of entering it. According to the Indian Income Tax Act, 1922, as amended, contributions to such a provident fund are not taxed, in so far as the aggregate of the sums so exempted does not exceed one sixth of the total income of the assessee, nor is the accumulated balance to the credit of the subscriber taxed.

The State Railway Provident Fund comes within the scope of this legislation. With certain specified exceptions, all permanent non-pensionable railway workers must subscribe, and some of those exempted from compulsory membership may become voluntary contributors. Payments towards a life insurance policy in the Post Office Insurance Fund may be substituted in whole or in part for subscriptions to the Fund.

The Fund is administered by the Governor-General-in-Council. Each member pays 8 1|3 per cent. of his monthly remuneration and the Government makes a like contribution. Interest on these sums accumulates to the credit of the member. A special Government contribution, varying with length of service, may be made where a member of the Fund retires after 30 years of service, or on attainment of 50 years of age (non-gazetted officers, 55), or on account of permanent incapacity or reduction of the establishment. When a subscriber leaves the railway service he is entitled to the amount standing to his credit in the Fund. Should he die, this amount is payable to his nominee, or, where none exists, to certain members of his family. Advances from the Fund to a subscriber for specified purposes may be allowed, but must be repaid according to the rules of the Fund.[1]

Recognised Provident Funds.

Recognition, in accordance with the provisions of the Indian Income Tax Act, 1922, as amended, is accorded to works provident funds which satisfy the conditions laid

[1] Cf. GOVERNMENT OF INDIA, RAILWAY DEPARTMENT (Railway Board): *State Railway Establishment Code*, Vol. I, 1945, pp. 116-140.

down in the Act. These are briefly as follows. The fund, consisting of accumulations of members' and employers' contributions with interest, must be vested in two or more trustees or in an official trustee under a trust which is not revocable save with the consent of all the beneficiaries. The member's contribution must be a definite proportion of his salary, and the employer's contribution, which must be credited to the member's individual account at least once a year, may exceed the member's contributions for the same period only in certain cases where an employee is in receipt of a salary of less than 500 rupees per month or where the regulations of the fund permit periodical bonuses. The accumulated balance to the credit of a member must be paid to him when he leaves the service of the employer maintaining the fund, unless he is dismissed for misconduct or voluntarily leaves his employment before the expiration of a specified term of service otherwise than on account of ill-health or other unavoidable cause. In the latter case his contributions, with interest, must be refunded and his employer must be allowed to make recoveries from the fund, in accordance with its regulations, up to the amount of his contributions to the member's account, with interest.

To meet certain specified needs the trustees may allow a member to withdraw part of his balance. Thus a withdrawal may be authorised for the purpose of paying expenses incurred in connection with the illness of the member or any of his family, or expenses which the member is obliged by his religion to incur in connection with marriages and funerals. Such withdrawals must be repaid in not more than 24 monthly instalments. A member may also be authorised to withdraw the purchase price of a house or life insurance premiums, on condition that the house or the insurance policy is assigned to the trustees.

Subject to specified maxima, the contributions paid by a member or his employer, the annual accretion to the credit of the former, and any accumulated balance paid to him are exempt from income tax. The accounts of a recognised provident fund are open to inspection by the income tax authorities.

Most of the provident funds maintained by private companies are recognised funds. Membership is usually optional either for all employees or for those who meet specified qualifications as to wage category and/or length of service. In a few cases membership is optional for those in the lowest wage brackets and compulsory for other employees. For example, only employees on a monthly basis are eligible for membership in the Associated Cement Companies, Limited, Provident Fund, and subscription is optional for eligible persons earning less than 25 rupees per month, compulsory for eligible persons earning more than this amount. Length of service qualifications, where such exist, vary from 6 months to 3 years.

A recognised provident fund must be vested in two or more trustees, or in the Official Trustee. Most funds are vested in a number of trustees appointed by the directors of the company. The rules of some funds state that cases of dispute are to be settled by arbitration, subject to the India Arbitration Act.

The rates of contribution vary in different funds ; those occurring most frequently are 6 1/4 and 8 1/3 per cent. of wages. In several cases the contributions are subject to a maximum of 50 rupees per month and a minimum of 1 rupee per month. Subscribers to the Imperial Chemical Industries Provident Fund are entitled to choose a rate of contribution varying from 3 to 10 per cent. of wages. The employer deducts the employee's contribution from his wages and pays it to the fund. Once (sometimes twice) a year he also pays into it, from his own resources, a sum equal to the member's actual contributions over the preceding year (or six months). Rules are usually laid down for the investment of the moneys in the fund and for crediting interest on the contributions in the individual accounts and for the closing and winding up of the fund.

A member who leaves the service of the company maintaining a provident fund automatically ceases to be a member of the fund; an employee may, in some cases, resign membership although continuing in his employment. On withdrawal from a fund the subscriber is always entitled to repayment of his own contributions with interest. If he

leaves the company as the result of incapacitating illness, reduction of staff or some other cause beyond his control, he is entitled, in addition to his own contributions, to the full amount of his employer's contributions on his behalf, plus interest; if he leaves voluntarily for any other reason after a prescribed period of service, he is entitled to his own contributions and a percentage of his employer's contribution, plus interest. This percentage increases with length of service up to a maximum of 100 per cent. The qualifying period usually ranges from 10 to 15 years and the percentage of the employer's contribution payable to the employee from 50 to 100 per cent. In several funds 25 per cent. of the employer's contribution is payable to an employee who withdraws from the fund after 3 years and the full amount if he has 12 years' service to his credit, while in others 10 per cent. is payable after 5 years' service and 100 per cent. after 20 years' service. Should a member of a fund be dismissed for misconduct, or leave without good reason, and sufficient notice, he has no claim on any part of his employer's contributions to the fund and the company is entitled to recover from its contribution to his account any claim for loss, damage, costs or expenses against him which results from his negligence, omission, fraud, or misconduct.

The rules of the funds provide that a member may furnish the company with a nomination, in an approved form, showing how he wishes his share of the fund disposed of at his death. The company or trustees need not recognise any other assignment of his interest in it. When a member dies, the trustees pay the whole amount standing to his credit to the persons or person entitled to receive it, irrespective of the deceased member's length of service.

There are also a few provident funds which do not meet the conditions for recognition laid down in the Indian Income Tax Act.

Statistics.

The effectiveness of a provident fund as a means of covering invalidity, old age and death depends on the proportion

of workers who belong to the fund and the proportion of members who qualify for substantial benefits. The few statistics available for 1944 and 1945 would indicate that the effectiveness of the funds is low, as regards the mass of the insured workers.

Of the workers on State railways, less than 28 per cent. belong to the fund. Among the 4,314 workers of the Associated Cement Companies, only 200 are members of the fund, although membership is compulsory for employees with a monthly salary of 25 rupees and over, and optional for other employees remunerated monthly. About 5 per cent. of the employees of two Bihar cement factories have elected to join a provident fund which is open to all workers having at least six months' service. On the other hand, the Empress Mills of Nagpur counts as many as 7,284 members in its fund, out of a labour force of 17,000.

High labour turnover prevents the average member from acquiring a right to a substantial proportion of the employer's contribution. For example, the Delhi Cloth Mills' fund had 11,267 members on June 1944; during the preceding twelve months 1,468 members withdrew, of whom 2 were entitled to the full amount of the employer's contribution and 68 to a percentage thereof varying from 25 to 75. This firm proposes to substitute compulsory life insurance for its provident fund.

Works Provident Funds in Burma

Several of the larger undertakings in Burma have set up provident funds, financed out of employers' and workers' contributions, and, as in India, many of them are entitled to special treatment for income tax purposes.

The Burma Oil Company maintains one fund for employees earning 30 rupees a month or more, and another for those earning less but having at least six months' service. The membership of the first fund was 2,570 at the beginning of 1945, and during the year 634 persons joined and 294 withdrew. Corresponding figures for the second fund were 1,321, 752, and 470 (including 136 persons who transferred to the first fund).

Provident Funds and Pension Schemes in Ceylon

In Ceylon, provision is made in the Income Tax Ordinance for provident fund contributions to be treated as non-taxable income. So far, 135 companies have received recognition of their funds for the purposes of exemption under the Ordinance. The Government has established a Provident Fund for employees not entitled to pension, which covers 9,627 persons. The State contributes at the rate of 7.5 per cent. of wages, the employee at 5 per cent.

Fifteen funds have been approved under the Wages Boards Ordinance for the purpose of deduction of workers' contributions.

The investigation into employers' services undertaken by the Commission on Social Services showed that, in the eleven years 1934 to 1944, 8,398 workers were paid benefits (including sickness benefit) amounting to over 4,500,000 rupees under the welfare schemes reported to the Commission. The majority of the schemes were found in commerce and business ; the schemes are generally contributory, the most common arrangement being a contribution of 5 per cent. of wages or salary by the employee and 10 per cent. by the employer.

As previously noted, the Commission has recommended the establishment of a comprehensive National Provident Fund for all employed persons. This scheme would provide for the continuance of existing funds where benefits to workers are not less favourable than those that would accrue to them as members of the National Fund.

Works Provident Funds in Indo-China

In Indo-China, a certain number of large private undertakings have set up provident funds or have created superannuation funds, either for the whole of the personnel or for the employees paid by the month. Some Government undertakings offer their workers a choice, in particular, the naval dockyards, where the workers can choose between membership of the superannuation fund affiliated to that of the French arsenals and participation in the local provident fund.

Welfare Funds

China

In 1943 the Chinese National Government issued regulations requiring public and private factories, mines and other industrial undertakings, and trade unions of craftsmen not working for a specified employer to set up welfare funds, committees and societies to provide living accommodation, hospitals, clinics, an employment service and certain amenities for wage earning and salaried employees and their families. Small concerns may set up joint welfare committees and societies.

An employees' welfare fund is financed largely by the employer, who, on the establishment of his business (private undertakings), sets aside a specified percentage of the capital investment for this purpose, and thereafter a percentage of his payroll, of his profits (private undertakings), and of the proceeds of the sale of waste material, while the employees contribute 1|2 per cent. of their earnings. A trade union welfare fund is maintained by an allotment of 30 per cent. of its membership fees. Under the chairmanship of the administrative head of the undertaking an elected committee of wage earning and salaried employees with representatives of the trade union, where there is one, administers the employees' welfare fund, and the affairs of their welfare society are in the hands of officials appointed by this committee. The society draws on the fund to provide services for the employees, either free of charge or on the payment of a small fee. Each fund must make public its annual financial statement and keep its books open for inspection by the competent authority.

India

Legislation has been passed to set up in the coal and mica mining industries of India welfare funds for the provision of public health and medical facilities, water supplies, adequate nutrition, housing, transport to and from work, and educational and recreational facilities, and for the general improvement of social conditions. The funds are supported by a tax on coal and coke (1 to 4 annas per ton) and on

mica (present maximum, 2 1|2 per cent. *ad valorem*) respectively. They are administered by the Central Government, which, in consultation with advisory committees on which employers and employees have equal representation, may make grants to provincial Governments, local authorities or mine owners for approved welfare schemes.

The Coal Mines Welfare Fund extends its activities to all aspects of the workers' welfare, but it concentrates especially on sanitation and health services. It has contributed 1,404,809 rupees to the Jharia Water Board to improve its water supply, and has undertaken to finance a water supply scheme for the Raniganj coalfield. Though clinics are to be maintained by the mine owners (several of whom already maintain dispensaries and hospitals) or by a special contribution to the Fund by the smaller mines, the Welfare Fund is constructing two central and four regional hospitals and several maternity and child welfare centres. Besides taking extensive anti-malaria measures, the Fund pays recurring annual grants to the local health authorities for the improvement of sanitation, and has also supplied them with ambulances. It has further recruited a tuberculosis expert and is planning the control of venereal diseases. The Fund, it may be added, plans to build 50,000 houses in self-contained townships of 5,000 each. It has set up vegetable farms, provided a mobile shop and canteen, and a talkie equipment.

Instructions have also been issued by the Central Government for the establishment of welfare funds in its undertakings. Each fund will start with a contribution from Government revenues, which will be gradually withdrawn as other contributions become available. The provincial Governments and principal employers' associations have been requested to take similar action.

Social Assistance

The Chinese Social Relief and Assistance Act

The Chinese Social Relief and Assistance Act, 1943 lays down rules for the organisation and maintenance of social assistance institutions by the Central and provincial Govern-

ments, municipal and district authorities, private organisations and individuals. At these institutions, which include homes, rehabilitation and training centres, and clinics attached to hospitals, certain indigent persons are to be given accommodation, training, and medical and maternity care. Assistance is also to be provided to them in the form of benefits in cash and in kind, low-priced food, low-rental houses and, in cases of property damage by flood, storm or plague, a remission or reduction of the land tax. According to the Act any person who suffers through unexpected calamities, such as war or famine, is entitled to emergency relief.

CHAPTER IV

BASIC ISSUES OF POLICY

Before a programme for the development of social security services can be drawn up, certain basic issues of policy ought to be decided. They include:

(*a*) the respective roles of social insurance and social assistance ;

(*b*) the expediency of a special programme for peasants ;

(*c*) the expediency of unifying and co-ordinating medical care services with general health services.

Social Insurance or Social Assistance

The Income Security Recommendation, 1944, indicates a definite preference for social insurance as the normal method of organisation for income security services, but envisages social assistance as the method to be used for furnishing children's allowances and, during a transitional period, for relieving necessitous persons who are not insured. The Medical Care Recommendation, 1944, looks to the development of either a universal insurance scheme or a universal free public service, with its own financial resources. The distinction between the two conceptions, when fully realised, is of little practical importance, since in either case the indigent are to receive the same care as those who actually contribute. Thus, for the right to a cash benefit the fulfilment of a contribution condition is imposed, whereas for the right to a medical benefit, need is the only criterion. This difference, it is believed, corresponds to present-day judgment and feeling about what is practicable and desirable.

In Australia and New Zealand, the traditional forms of social insurance have not been adopted: they have been re-

jected in favour of a universal income security service, the benefits of which are available at the standard levels only to persons of small means, and a medical care service (which in Australia is as yet incomplete) freely available to all. The two services are financed largely from a special income tax, to which even the unskilled wage earner is liable. Until recently the Australian scheme was financed from general taxes, and the introduction of the special tax is a significant change. The standard levels of the cash benefits correspond to minima of subsistence and are reduced in respect of any resources of the beneficiary exceeding a prescribed amount. This system avoids the keeping of contribution accounts, and has the advantage of easy universality, but it does involve the application of a means test, and therefore delay, whenever a cash benefit is claimed.

It would seem that this system can only be applied in a country in which the collection of income tax is highly organised and is effective in relation to all classes of the population. At the present time the countries where this condition is satisfied are comparatively few in number.

A country has to raise money for necessary or desirable purposes as best it can: it is never easy. If tangible benefits, especially in cash, are to be granted to members of a group in circumstances which, as each of them knows, may well be his own, it has always proved possible to finance the benefits in part by an insurance contribution, where the imposition of a tax without immediate connection with the benefit would have encountered strong resistance. But only as regards wage earners has a means of effectively collecting contributions from the mass of the population been found: it is that of collection by the employer.

No method of equal efficacy has been found for levying a contribution or direct tax on independent workers of very small means, and especially on peasants with an insignificant cash income. This means, not that imperfect methods should not be resorted to or new devices essayed, where the classes concerned could pay without hardship, but that general taxes may have to be drawn upon to finance a minimum of medical care for these groups, in the general interest as well as for the benefit of the groups themselves.

The Social Relief and Assistance Act promulgated by the National Government of China in 1943 is a comprehensive code of social security and welfare, generously conceived, providing every necessary form of help and care to persons in distress. The Conference will doubtless wish to learn what progress has been made in the application of this law, and what confidence the Government places in its future development as the principal guarantee of social security. In view, however, of the fact that the law envisages general taxation as the only source of revenue for meeting the cost of the manifold benefits to be provided, it is to be apprehended, for the reasons indicated above, that the application of the law will encounter serious financial obstacles. If the cost of maintaining persons who are unable to earn but normally belong to the wage earning class, and the dependants of such persons, is covered by the contributory income of a social insurance scheme, and if the cost of a medical care service is likewise met from the same or a similar source, the scope and burden of the residual services to be furnished in the form of social assistance will be greatly lessened, and the possibility of administering such services, still extensive and variegated enough, on an adequate scale will be correspondingly more likely. The residual services will be characterised by the abnormality of the individuals or the situations with which they have to deal. They will therefore include the relief of the victims of natural catastrophes, and institutional care for infirm and other persons who cannot or should not live by themselves.

Social Security for Peasants

The overwhelming majority of the people of the countries under consideration are engaged in agriculture or in other rural pursuits. How can social security be provided for them ?

The Income Security Recommendation, 1944, does not single out agricultural workers for special treatment. It is applicable to agricultural communities which operate under a money economy, and in which social security necessitates security of cash income. But it does not cater for peasants cultivating on a bare subsistence basis

It must be said at once that, with few exceptions, all existing social insurance schemes have been designed with the needs of urban, and especially industrial, wage earners in mind, and the techniques they use are, for the most part, only applicable to employed persons.

In so far as the agricultural worker is regularly employed as a wage earner he can be brought within the scope of a social insurance scheme of the same general form as that established for the urban wage earner: this would appear to be possible at least in the case of workers employed on large plantations. A definite wage exists, though it may be only partly in cash; contributions can be collected through the employer; cash benefits can be administered efficiently; the provision of medical care can be organised.

But the problem of social security for the tenant farmer and the peasant proprietor, not to mention the casual farm labourer, requires quite a different approach.

For the independent cultivator, whether he rents or owns his holding, social security (supposing, indeed, that under average conditions he can earn enough to support himself and family) surely means first of all security against the loss of his crop or his livestock. The time when he is of the greatest value to the community is in early middle life when he is still strong and his family responsibilities are at their maximum. At this time neither death nor serious illness is likely. Yet the family can be brought to ruin, comparable to permanent unemployment for the urban worker, by a climatic catastrophe or by diseases destroying plants or animals. These disasters are, to a considerable degree, preventable by agricultural engineering works or by veterinary and weed and pest controls, and by instruction. The necessity of these measures is well understood by the Governments of the Asiatic countries concerned, and their application will certainly be greatly extended in the future.[1]

The risk that remains, however, may still be large. A special relief organisation to deal with famine has long been maintained by the Indian provinces and in Burma: the re-

1 See, for example, GOVERNMENT OF BOMBAY: *Post-war Reconstruction, Bombay Province*, 1945.

lief normally takes the form of employment on public works, preference being naturally given to irrigation works. The Chinese Social Relief and Assistance Act empowers local authorities "to set up granaries as a precautionary measure against a possible food shortage, so that foodstuffs may be loaned to the poorer classes free of interest or at low rates of interest, subject to repayment at the next harvest"; it also provides for the remission of land tax to localities stricken by calamities.

In Ceylon, provision is made by law for special expenditure up to 250,000 rupees—increased to 2,400,000 rupees in 1945-46—for relief of distress due to failure of crops, floods, and other exceptional causes. Granting of food and relief in cash on account of damage to houses are among the measures taken in the event of floods. The chief method of relief in the event of drought or failure of crops is relief work; free rations are given where such work is not expedient, and free seed is usually provided by the Department of Agriculture.

The development of an insurance scheme to cover the loss of crops and livestock is an idea which deserves examination. The Office has very little information on this subject, but it is obvious that such insurance faces very difficult problems of fraud and valuation besides necessitating a very wide distribution of the risks. It is for consideration whether the Office should endeavour to collect information on this subject.

The fact that a small farmer's or share farmer's income is irregular, while his expenses are bound to be regular suggests the need for some kind of social system under which he can obtain the necessary advances of funds; for in the absence of such a system, he frequently has resort to usurers and falls seriously into debt. For small owners who are in a position to borrow on the security of their property, rural credit co-operatives can carry out this function. A similar institution based on co-operation would be useful for share farmers, although more difficult to organise owing to the uncertainties of the harvest. The question of agricultural credit systems is discussed in more detail in Chapter I of Report II, but their function is in many respects too like

that of social security systems for them mentioned not to be here.

The risks of sickness, accident, invalidity, old age and even death do not have the same meaning for the cultivator as for the urban wage earner. His earnings do not take the form of fairly equal payments received at short intervals, normally throughout the year. In part he consumes his own produce, in part—often a minor one—he sells it, his cash receipts being concentrated perhaps in a single transaction following the harvest of his main crop. His activity is likely to fluctuate greatly in intensity with the seasons. All the family share as they are able in the work of the farm, and the larger the family the greater the elasticity in the distribution of the tasks.

The economic loss from sickness thus depends on the time of year and it may be nearly the same whether it is the father, the mother or an elder child who is affected. The loss, however, can, to some extent, be made up by harder work on the part of other members of the family. In any case, it will be difficult, if not impossible, to evaluate the loss at all precisely, or to ascertain whether the person certified to be sick is really abstaining from work.

Invalidity and old age need not signify for the cultivator, as they do for the urban wage earner, the total cessation of earnings, since the farmer can usually continue to carry out some minor task in the family concern. Premature death, involving the loss of the chief breadwinner of the family, is an economic disaster; although, if the deceased was the owner of the land he worked and was free from debt, the widow will have some resources at her disposal.

Insurance against the three risks of invalidity, old age and death, in most countries, includes an element of compulsory saving, since the benefits are proportionate to the number of contributions paid. The cultivator, however, is likely to prefer to invest his savings in improving and extending his farm, expecting to get a larger return from them by this means than by that of deposit with an insurance fund. Consequently, he may be reluctant to enter into an insurance scheme of this type.

A medical care service, in contrast to the cash benefits of social insurance, is as indispensable to the rural as to the urban population. Naturally, it is not easy to convince the agricultural community of the value of medical care to the point of being willing to contribute towards the cost; but certitude that the service will ultimately be appreciated warrants the public authorities in making the necessary effort of propaganda and the necessary initial expenditure.

It seems clear, therefore, that the cash benefits of social insurance are not a primary need for cultivators: for them social security means first of all security that their work will be rewarded with an income sufficient for subsistence.

Nevertheless, even when the efficiency of agriculture has been raised, and the average income has been increased, invalidity, old age and death will continue to create indigence in the villages, especially among landless labourers. It seems that some attempt should be made to organise the relief of the indigent, and not leave them with beggary as their sole resource. There is no question, at this stage, of introducing a formal scheme of compulsory insurance. It is a matter of considering what simpler arrangements could be devised. Is the co-operative movement capable of collecting and distributing a local fund for general relief? Would it be possible to revive or fortify the ancient charitable institutions and customs, such as those still prevalent in Siam, Burma, and other Buddhist countries? Could each village or district set aside a piece of land the produce of which would be used for relief, as in Annam, where there still are traces of the system of collective responsibility for the village poor instituted by Emperor Gia-long a century and a half ago?

The question of the possibility of paying contributions in kind instead of cash also requires examination.

When, however, the cultivator's economic condition has risen well beyond the subsistence level, the arguments for introducing cash benefits become stronger. Indeed, it is only then that the principles of the Income Security Recommendation become relevant to the independent cultivator. As income increases, and a greater proportion of it

is in cash, the cultivator can afford a contribution. Young children and the wife take a smaller share in the work of the farm, so that the dependence of the family on the continued working capacity of the father is greater. Widespread literacy and greater facilities for operating an efficient administrative system, notably as regards medical care, should make possible the introduction of certain cash benefits for the risk of incapacity for work. At the same time the cultivator becomes more aware of the desirability of protecting his family against premature death, by some form of life insurance. The family tends to become a smaller social unit, in which the presence of grandparents is felt as increasingly irksome. It is then that the utility of assuring the economic independence of the aged by means of old-age pensions begins to be understood, not only by the aged, but by their children as well.

The cash benefit that has been most widely extended to independent cultivators is indeed the old-age pension. In Sweden and Finland, the old-age insurance scheme applies to cultivators in the same way as to every other citizen. Bulgaria has a special old-age insurance scheme for peasants who are members of co-operative societies; it is financed by a uniform contribution from every member and by a tax on the exports of agricultural produce. In New Zealand, Australia and the United Kingdom, the universal social security schemes grant all or most of their benefits, including old-age pensions, to all citizens, whatever their occupation; Denmark, Norway, Canada and the United States provide universal old-age pensions or assistance. All these schemes draw a substantial part of their revenue from general taxation.

A few countries have made an effort to insure, not only the agricultural employees, but also their employers against accidents. While the accident risk becomes more serious where power-operated machines are used, it may be an important cause of incapacity in other circumstances, for example, where the handling of animals is involved. In its application to agricultural work, and especially to that of the independent cultivator, the limitation of the risk covered to that involved in definitely agricultural work

seems unpractical and unnecessary: the risk should include that of any traumatic injury not provoked by the victim. Further, the persons insured should include the members of the family who work on the farm, as well as the hired labourers. If the cash benefits are fixed according to a simple, rough-and-ready scale, if they are granted only in cases of a certain severity, and if an organised medical care service is already available, an accident insurance scheme is not difficult to administer for the agricultural population which desires it.

Organisation of Medical Care

The adoption at Philadelphia of separate Recommendations on income security and medical care was a sign of the times, a recognition of the supreme importance to society of the health of its members and the necessity for a rational organisation of health services generally. Hitherto, only the well-to-do and persons protected by highly developed schemes of sickness insurance have enjoyed the security of being able to obtain adequate care. It has now become a question whether adequate medical care should continue to be confined to a limited class of insured persons or should, at least in principle, be rendered accessible to the people at large. This issue is discussed in Chapter VI.

CHAPTER V

DEVELOPMENT OF INCOME SECURITY SERVICES FOR WAGE EARNERS

Introduction

Assuming that the Asiatic countries will seek to develop their income security services for wage earners on the basis of social insurance rather than social assistance, and that the standards to be aimed at for these services should, generally speaking, be those laid down in the Income Security Recommendation, 1944, a series of problems arises concerning the transformation of the present elementary forms of these services.

It has been shown, in Chapter III, that workmen's compensation and maternity benefit have been made a legal liability for the employer in the case of industrial undertakings of a certain size or hazard and of plantations. In a number of large undertakings the employer has, on his own initiative, established sickness benefits of a modest, but still useful type, and provident funds to care for the invalidity, death and retirement of his workpeople. In China there is a scheme of social insurance for salt miners which, although small and experimental, is the first to be put into operation in any of the Asiatic countries under consideration. China has a tentative draft of social insurance for industrial wage earners ; a Bill providing for the insurance of persons employed in factories against sickness, employment injury, and maternity has been tabled in the Legislative Assembly in India; in Ceylon, a social insurance plan for all employed persons and a social assistance plan for the population as a whole have been put forward by the Commission on Social Services.

In European countries, 20 to 60 years ago, the types of income security schemes in operation were like those of

today in the countries here considered, with the important difference that in Europe there was already a lively mutual aid movement among the workers. In a number of Asiatic countries, such as India, Burma, Ceylon, and others, the mutual aid movement in European countries has a parallel, however, in the mutual aid given by members of a family to each other, and also in the assistance given in the name of religion.

Until quite recently the evolution of social insurance institutions followed the principle that the organisation of insurance should follow the division of risks according to causes, without regard to the similarity of the consequences which risks of different origin may entail for the victim. Several branches of social insurance were recognised and developed for employment injury, sickness and maternity, invalidity, old age and death, and unemployment. During this long process, institutions specialised in the administration of these branches took deep root and acquired a great power of resistance to measures threatening their individuality.

The competence of the institutions might be local, regional or national, or occupational : in Germany, for example, sickness insurance was local ; pension insurance, regional for wage earners, national for salaried employees ; unemployment insurance, national ; employment injury insurance, occupational. There might be three insurance medical services : for sickness insurance, pension insurance (treatment of invalids), and employment injury insurance. Four distinct contributions might be collected in respect of the same insured person. Temporary loss of wages from sickness, employment injury or unemployment might be compensated in different proportions ; permanent incapacity, in most countries, would involve a high benefit if the cause was an employment injury, a low one if not. In sum, social insurance, in the countries where it had the longest history, the widest scope, and most extensive benefits, was exceedingly complex, unintelligible to the insured person, costly to administer, bristling with anomalies. Of course, from the standpoint of each branch of insurance, with its own

traditions and philosophy, the provisions of its law seemed consistent enough : the anomalies became apparent only to the insured person and the employer in their contacts with different schemes, and to the outside critic.

Nevertheless, a limited measure of co-ordination had been achieved by 1939. The countries of eastern Europe, having studied the complicated structure of the German social insurance system, and having a clearer field for their legislation, adopted schemes exhibiting greater unity and consistency. The same policy has been followed in the schemes established during the last few years in Latin America. Finally, the United Kingdom and France have succeeded in applying this policy in the codification, revision, and extension of their systems ; while several other countries are planning to do the same.

In the Asiatic countries here under consideration, the question arises : shall they, in promoting the development of social security services, follow, as the European countries did for many years, the line of least resistance, improving and extending each type of institution or law separately, in accordance with its inherent and, as it were, natural, possibilities; or shall they endeavour to take a short cut, straight in the direction indicated by the most modern thought ; or is there some intermediate policy that would be more expedient ?

In the following paragraphs an attempt is made to state some important considerations that should be taken into account in answering this question, which, the Office believes, is the main issue in devising a social security policy. Problems of policy concerning the organisation of medical care services are dealt with separately in Chapter VI.

Development of Social Insurance by Branches

Schemes of employment injury insurance and sickness, invalidity, old-age and survivors' insurance could be developed from the existing employers' liability and voluntary provisions to be found in Asia today.[1] For the workmen's com-

[1] The unique and experimental Chinese salt miners' scheme is in line with the alternative approach indicated in the next section of this Chapter (pp. 59 *et seq.*).

pensation laws, maternity benefit laws, sickness funds and works provident funds could each be made to evolve into a branch of social insurance. European experience shows that this is possible and illustrates how the evolution might proceed in the course of several decades.

The transformation of workmen's compensation might come about in the following way. The workers will press for higher and still higher rates of compensation, and better medical care, and will succeed in their demand ; one reason for their success will be that there is as yet no compulsory sickness, pension or unemployment insurance to compete with workmen's compensation for a share of the product of industry. The workmen's compensation laws, based as they are on the liability of the individual employer, will be found to afford insufficient security to the victims of employment injuries, and the situation will be aggravated by the higher rates of benefits. Employers will be required to find insurance companies to carry their risks. There will be complaints from employers that the companies charge excessive premiums or refuse to accept unprofitable risks. Employers in this and that industry will set up their own mutual insurance companies to operate at cost. The State will be led to establish an insurance fund to compete with the insurance companies, give cover to rejected risks, and, by some means, pay compensation in cases when the employer fails to insure. Dissatisfaction will arise among the workers with the obstructive attitude of some insurance companies in the handling of claims. At last the State, in the face of strong opposition from the now well-established insurance companies, will take over employment injury insurance as a monopoly, to be administered with the participation of representatives of labour and management.

This process may take fifty years, as it has done in the United Kingdom and France. The result is likely to be an excellent scheme in itself even if, for lack of local organs, it cannot be enforced upon small employers ; but its very excellence will be an obstacle to its co-ordination with other branches of social insurance, and the disproportionate resources absorbed by it will prejudice the provision of a bare minimum of benefits by the others

Maternity benefit will probably remain an employers liability until a scheme of compulsory sickness insurance has been developed which can administer it. The grave objections to placing the liability for this benefit on the employer individually are that he is tempted to discharge his women workers as soon as they are known to be pregnant, and that they are afraid sometimes to claim the benefit. For these reasons the Childbirth Convention, already in 1919, insisted that the benefit should be paid by a public fund or an insurance fund. Very few countries, however, have opted for the creation of a public fund, despite the eminent concern that the State might be expected to have for maternity.

Compulsory sickness insurance might begin in the larger undertakings of industry and commerce. Those with a staff of say 500 or more would be required to set up a works fund in conformity with a set of model rules, concerning membership, minimum contribution rates, the share of the contribution to be paid by the insured person, the nature and minimum rates of benefits, etc. Since the funds would have to arrange for medical care of a certain standard to be furnished to their members, and since the existing medical facilities are presumably insufficient, sickness insurance can only be expanded as the development of those facilities allows. The contribution, and particularly the employer's share of it, would have to be kept very low until substantially all competing undertakings have been brought into the scheme. The inclusion of smaller undertakings could be effected by setting up general local funds, to which the workpeople of these undertakings would be affiliated. Such was roughly the policy followed in Japan and most European countries for the introduction of compulsory sickness insurance.

The works fund creates a desirable solidarity of interest between labour and management and among the different classes of the staff ; and easy mutual supervision effectively checks unjustified claims. The works fund can, if it wishes, supplement the minimum benefits prescribed by law and so adapt them to the peculiar needs of its membership. Its

administration expenses are low. But the works fund has serious disadvantages. Its sickness experience depends in part on the kind of production in which the undertaking is engaged : benefit will tend to be low in the more unhealthy trades. If the works fund is responsible for furnishing medical care, it will probably have difficulty in making the necessary arrangements for an adequate service. Again, the works fund shares the economic fortunes of the undertaking, and the dismissal of a substantial proportion of the staff or a reduction of their wages may upset its finances. In Europe, works funds have constantly lost ground to the general local funds. The works fund has not been encouraged by the State because its efficiency and solvency are difficult to secure by supervision ; and it has been disliked by the trade unions because of the often preponderant influence of the employer in its administration.

General local funds, if not created at the same time as sickness insurance is made compulsory, must be set up soon afterwards in order to administer the insurance for workers in the smaller undertakings and to take over responsibility for insured persons whose works funds are no longer able to operate. General funds have naturally a larger, more stable membership and a more regular sickness experience than works funds, and if they have to organise the provision of medical care, they are in a better position to make the necessary contracts with the medical profession and the hospitals. Though its administration lacks the intimacy of a works fund, the local fund, grouping, as it does, a variety of trades on the same terms, favours the growth of solidarity among the working population of the entire district served. The general local fund has been found to be a suitable institution for administering not only sickness insurance but also the local business of other branches of social insurance.

The works provident funds which many large undertakings have established for their workpeople represent a praiseworthy attempt on the part of the employers concerned to ensure the payment of a benefit in case of invalidity, death or old age. A worker who remains in the service of the

same employer for 15, 20 or 25 years and keeps intact the sum accumulating in his account is entitled to a substantial, and even adequate, benefit on retirement ; on leaving the undertaking, however short his service has been, his own contributions are always returned to him ; and he can, while employed in the undertaking, borrow from his contributions to meet certain emergencies. That the provident fund promotes the social security of the worker is obvious. Compulsory saving is even preferable to compulsory pension insurance as long as there is a large turnover among industrial workers and the interchange of workers between industry and agriculture remains frequent. The provident fund, meanwhile, encourages the formation of a stable labour force.

As soon as the labour in a particular area has, in the mass, settled down to regular employment therein, it will be time to consider converting compulsory saving into compulsory pension insurance. The process might be somewhat as follows. The larger undertakings in the area might be required to set up provident funds complying with uniform basic conditions, one of which might be the obligation to transfer the worker's contribution and a proportion of the employer's contribtion from one fund to another; contributions would not be returned to a member unless he could show that his intention is to leave definitely the field of employment embraced by the undertakings in question. The benefit would normally take the form of a life annuity bought with the proceeds of the worker's and his successive employers' contributions. A minimum of protection in case of premature death could be secured by means of group life insurance policies financed by part of the employers' contributions. A similar minimum in case of invalidity would be more difficult to introduce: the risk is not one which either a works fund or an insurance company is fitted to handle.

Provident funds cannot be operated by the small undertakings in which the majority of urban workers are employed. As in the case of compulsory sickness insurance, it will eventually be found expedient to set up a general

regional insurance fund to receive contributions from the smaller undertakings. The benefits of the general fund, however, will probably be of a more modest character than those of certain works funds. Finally, we may expect to see a single general scheme securing uniform basic benefits for all the employed persons in the region, and works funds furnishing supplementary benefits for their members who have a long record of service in the undertaking concerned.

The substitution of insurance for saving will afford a high degree of income security to the worker in invalidity or old age and to his dependants at his death. It will deprive the worker of facilities offered by the provident fund for borrowing in certain emergencies, but of these, sickness and, later, unemployment will be cared for by insurance. And it is pertinent to add that the pension will not be subject to attachment for debt.

Development of Social Insurance as a Whole

In contrast to the policy of developing social insurance by branches, which was followed in western Europe, several countries of eastern Europe and Latin America have, from the outset, planned for the ordered extension of a single general scheme of social insurance by adding new groups to the insured population and covering new risks. The following paragraphs offer for consideration the outline of a policy that might be adopted in Asiatic countries for the gradual creation of an integrated income security service for wage earners, based on the method of social insurance.

The first step is to set up an experimental scheme for the purpose of ascertaining : the most efficient administrative procedures for the collection of conditions and the payment of benefits; the costs, and therewith the suitable rates of contribution and benefits; the most suitable administrative organs, with special reference to convenient coordination with the medical care service, and to the effective participation of insured persons and employers in the control of the scheme. The area chosen for the experiment

might be a town of medium size in which a variety of industries are carried on and which contains several large factories, so that most of the situations and problems arising out of the application of social insurance to urban wage earners will be met with. An experiment in the organisation of an adequate and economical medical care service should be conducted simultaneously, and, in order to avoid delay, it is desirable that the town should be one that already possesses hospital facilities that are more ample and efficient than those found in most towns of equal size.

The experimental scheme should be administered by a board, consisting of experts appointed by the State and of employers' and workers' representatives. The board should have wide powers of making regulations within the framework of a law that lays down broad principles only. Because the scheme is likely to be expensive to operate at first, and in order to allow freer scope for experiment, the State should, whether or not it intends to subsidise the permanent scheme, take over part of the worker's contribution, which would be fixed at a merely nominal amount until a satisfactory benefit service is provided. The employer's contribution would naturally include the estimated cost of any benefits for which he was previously liable but which are now furnished under the scheme; it might well include also a portion to be used for financing the capital expenditure needed for the provision of medical facilities, if medical care is an insurance benefit.

As soon as the application of the experimental scheme has advanced to a stage at which the main features of the scheme can be pronounced to be satisfactory, preparations can begin for the introduction of a permanent scheme in a number of similar areas. Surveys of population, industries, and medical facilities can be carried out. If medical care is to be furnished as an insurance benefit, it should then become feasible to levy on the employers of the future insured population a provisional tax—in the form of the contribution they will eventually pay or some other form—to be used for developing the necessary medical facilities in their respective areas. It is assumed that the State will meanwhile

have begun to encourage the training of medical and auxiliary personnel on a large scale.

The experimental scheme should preferably apply to all undertakings in its area which are above a certain, small size. The enforcement, from the outset, of the obligation to pay contributions in the case of very small employers and their workers is likely to prove too difficult and expensive: the inclusion of the small undertakings should await the demonstration of the smooth working and utility of the scheme as applied in the larger undertakings. The undertakings to which the scheme applies should, however, be a representative sample of the variety which will be found in other urban areas. It is necessary to observe the relevant characteristics of different industries and sizes of undertakings, and to follow the course of a worker from one undertaking to another, his unemployment, and, it may be, his periodic absences from the area.

Sickness, Maternity, and Employment Injury

The risks covered by the scheme from the beginning may include sickness, maternity, and employment injury. These three risks have the following features in common : medical care as the principal benefit, and cash allowance the accessory ; the vivid awareness, in the mass of the insured population, of the distress caused by these contingencies ; the feasibility of covering these risks by insurance even in respect of a labour force which has a high rate of turnover.

Differentiation between Sickness and Employment Injury Benefits.

A fundamental question that must be answered by the designers of the scheme is : what place is to be given to employment injury benefits as compared with benefits for contingencies having similar consequences for the victim but arising outside the time or place of employment? There are, broadly speaking, two answers.

The first, which has the support of most countries to-day, is to distinguish sharply between the rates and conditions of benefit, according as the contingency—accident or disease,

incapacity or death—originated in the employment or not, and to grant much more favourable treatment to the victims of employment injuries. One reason for this differentiation is that, as already mentioned, workmen's compensation started well before sickness, pension or unemployment insurance. Another is that the ease with which the cost of compensation could be transferred through the employer to the consumers of the products of dangerous work, could—as long as insurance was not introduced—at the same time encourage the relatively safe undertaking : high benefits favoured an active safety policy on the part of employers, who, and not the workers, could initiate it. Even when employers, voluntarily or compulsorily, resort to insurance to cover their liability, it is still possible to adjust premiums to the degree of risk ascribed to undertakings individually in the same branch of production. The limits within which it is possible to vary premiums under a system of merit rating are, however, necessarily narrow if the past experience of the undertaking is to be the index, while the cost of detailed surveys is prohibitive, save in the case of large undertakings, if the actual machinery and discipline of the undertaking are to be the index.

The second answer, even though it is but sparsely illustrated in national practice, may be the more appropriate in Asiatic countries now, just as it may also gain increasing favour elsewhere. It is to distinguish as little as possible between the benefits of social insurance on the ground of their origin within and without employment respectively.

Especially in Asiatic countries, simplicity must be a primary consideration in the drafting of the scheme : there can be no question of expecting workers, largely illiterate or as yet unaccustomed to long-drawn legal procedure, to acquaint themselves with complicated regulations. More than elsewhere, rough, straightforward rules must be preferred to those which attempt, for reasons of fine equity or of avoiding minor abuses, to recognise in their elaboration of detail a multitude of variants in the circumstances of individuals. Occasions for dispute, leaving a sense of injustice in the defeated claimant, must be reduced to a minimum.

The most important difference between employment injury benefits and those of other branches of social insurance is that the rates of the former are usually higher, sometimes twice as high. Yet the need of the sick or injured person or his survivors is the same whether the accident or disease occurred, or was contracted, in connection with employment or not. It is suggested that the rates of benefit in case of incapacity and death should ultimately be the same, irrespective of the cause of the contingency. At present the benefits of the workmen's compensation laws of the Asiatic countries are by no means excessive, and therefore it should be possible, from the outset, to fix the temporary incapacity benefit in case of employment injury and the sickness benefit at the same rate under the experimental scheme; the same basic wage and the same waiting period could be used also. As a rule, therefore, it would not be necessary to prove that an injury was connected with employment before any benefit could be paid. Other differences usually made between temporary incapacity benefit in respect of employment injury and sickness benefit are less easy to remove: they relate to the qualifying period of insurance and the length of the benefit period.

Benefit Conditions.

Whereas the temporary incapacity benefit is always granted without regard to the time during which the victim has been employed or insured, the grant of sickness benefit is sometimes conditional on the claimant's having been insured for a minimum period. So long as the scope of compulsory sickness insurance is limited, individuals who know that they are bad risks can enter insurable employment in order to take improper advantage of the benefits offered. The extent to which this practice is resorted to will depend on several factors: the magnitude of the benefit, the spread of knowledge about the scheme, the number of persons not in insurable employment but ostensibly eligible to enter it, and the propensity of employers to help persons, especially relatives, at the expense of the scheme. The danger of fictitious employment can hardly affect employment injury insurance, but it may be appreciable as regards sickness in

surance, while for pension insurance it may be serious. It will be for the experimental scheme to discover whether it is expedient to make the grant of sickness benefit conditional on the fulfilment of a qualifying period of insurable employment. The decision has an important effect on the administrative procedures of sickness insurance.

Temporary incapacity benefit in respect of employment injury should, and in most countries, does continue until the injured person is certified to be fit to resume work or to be permanently and totally incapacitated; if the incapacity is found to be permanent, a different and appropriate benefit is substituted for the temporary incapacity benefit. Even if the existing workmen's compensation law of the country concerned limits the duration of temporary incapacity benefit to a maximum number of weeks or months, this limitation should not be carried over into the experimental scheme. It is questionable, however, whether the same rational policy of supporting an incapacitated person until he can resume work should be adopted from the outset in the case of sickness benefit. Here, it seems, reason may have to give way to prudence. Incapacity due to sickness is many times more frequent than that due to employment injury, so that there is a serious cost factor to be considered if the duration of sickness benefit is to be unlimited. Again, it is not suggested that the risk of incapacity for work not originating in employment should be covered in its entirety under the experimental scheme : lengthy illness and invalidity might be excluded.

It may rightly be objected that it is inconsistent to propose that sickness benefit should be fixed at the same rate as the temporary incapacity benefit for employment injury, but that the maximum duration of the former, but not the latter, might be limited, not only under the experimental scheme, but also, in its initial phase, under the permanent scheme. The reply must be that although the long-range purpose is to treat contingencies of different origins but like results in the same way, the process of assimilation can only be gradual, and that the equalisation of the two rates of benefits seems a practicable first step. It is hardly neces-

sary to explain that the provisions of the experimental and of the permanent scheme have to effect a compromise between what the expert judges to be of advantage to the insured person and what the latter, and his employer too, appreciate, or can be led to appreciate, as insurance benefits. For example, the ordinary person knows that he often suffers a short illness, appreciates benefit for that, and wants the rate of that benefit to be as high as possible ; but he does not expect to be the victim of serious illness and is not interested in paying the additional contribution required to cover that risk. It is only gradually that the public learns to be provident in the matter of contingencies that, though serious, are unlikely.

The experimental scheme will of course provide benefits in case of permanent incapacity and death that are caused by employment injuries, for they are already provided by the existing law. These benefits should be designed and developed according to principles that can later be applied to other cases of permanent incapacity and death.

For the sake of economy and efficacy, the accent of policy in relation to permanent incapacity will be on rehabilitation. While one country can afford to pay substantial compensation in case of mutiliation, even if no loss of earnings results, another country may have to content itself with a nominal sum in such a case, provided that the injured worker is rehabilitated to the point where he can effectively earn as much as he did before. Compensation in serious cases of permanent incapacity should always take the form of a pension unless it is clear that the capital equivalent will be used by the beneficiary in a more advantageous way.

The claim of the survivors entitled to compensation in respect of death caused by employment injury should preferably be based on the fact of dependency, subject to the overriding rule that the widow and the children too young to work should be deemed to have been supported by the deceased. However, it is questionable whether substantial compensation ought to be paid to a young and childless widow in circumstances where genuine opportunities for self-support exist. In this connection the suggestion, con-

tained in the Beveridge Report, that such widows should be assisted to obtain suitable employment deserves attention. Although to compensate widows on the same terms regardless of their earning capacity, if the death is caused by employment injury, is almost universally the practice today, yet, if the death is caused otherwise, the usual rule is to pay benefit to the widow only if she can be presumed to be unable to maintain herself ; and there seems no sufficient reason—where economy is a primary consideration—for not adopting the latter policy in all cases. Survivors' benefits should, of course, be pensions payable during widowhood or while the child is attending school, as the case may be.

Funeral benefit may well be provided under the experimental scheme. It might be supplied in kind, in a decent and economical manner.

Rates of Contribution and Benefit.

For the basis of contribution and benefit rates, the experimental scheme can try using either the wages of the individual or wage classes each embracing all workers whose wages lie between the limits of the class; probably the latter will be found the more convenient. The fixing of contributions and benefits at uniform absolute amounts, subject perhaps to variations according to the number of dependants, is probably unsuitable in countries or communities where there is a wide difference between the earnings of unskilled wage earners. The employer's contribution for employment injury and maternity benefits should be combined with the joint contribution for sickness benefit and possibly medical care, and should not, as a rule, vary according to the probable risk or the actual experience of each undertaking : uniformity of the rate of the employer's contribution will greatly simplify administration. The levy of an additional contribution on large, dangerous undertakings may, however, be provided for. Reliance on merit rating to encourage accident prevention may be replaced by much more thorough factory inspection, by education of employers and workers in safety measures, and by suing for the refund of

benefits and prosecuting employers in whose undertakings accidents occur as the result of failure to observe legally prescribed safety rules.

When the experimental scheme has found satisfactory solutions for the many problems of detail that have been met with, is working smoothly, and has elaborated complete regulations, forms and an accounting system, it can be made permanent. It can then be introduced successively in all other localities where the conditions are broadly similar to those in which the experiment was conducted, as soon as the necessary medical facilities are ready. Then, for a large proportion of urban wage earners and their families, there will be a sound system of income security in respect of sickness, maternity, and employment injury.

Other Risks

Consideration can then begin of the problems of adding unemployment, invalidity and death not due to employment injury, and old age to the range of risks covered. These new risks are characterised, much more than sickness or maternity, by the fact that insurance against them can only be organised if the insured population is composed of individuals who are normally and regularly occupied in insurable employment. For, so long as the scope of the insurance scheme is limited, it will be necessary to impose a substantial qualifying period as a condition for the grant of any of these benefits.

Unemployment Benefit.

Nevertheless, if a qualifying period of, say, six months of insurable employment during the year preceding the claim for benefit has been imposed as a condition for the grant of sickness benefit, it might be possible to grant unemployment benefit on the same condition in areas in which employment offices have already been set up and are operating satisfactorily. In fact, the rate, waiting period, and maximum duration of unemployment benefit might be the same as those of sickness benefit ; and the two risks might be combined, so that the total duration of both benefits should not exceed a prescribed maximum. It should be

noted that the imposition of a long qualifying period demands that the scope of insurance should be extended to the whole field of urban employment, and not only to employment in undertakings of a certain size.

Pension Insurance.

The benefits of a general scheme of pension insurance can be designed according to either of two distinct patterns or to a combination of both.

Pensions of the first pattern do not vary with the number of contributions paid : the pension instalments may be uniform absolute amounts, or uniform percentages of a wage—either an average wage for a group or for an individual. Such benefits correspond to the notion of group insurance in its present form. The insured group has a group risk, more or less constant from year to year, of invalidity, survival beyond the pensionable age, and death. A constant premium enables benefits to be paid in respect of all members of the group to whom these contingencies occur, without regard to the duration of their membership. So long as the scope of insurance is limited, individuals who know they are bad risks can introduce themselves into the insured group in order to take undue advantage of the protection offered. It is therefore necessary to impose a qualifying period on new entrants, just sufficient to serve as a deterrent; but in reckoning that period, the time that a person has already spent under the sickness insurance scheme should be included. Pensions of this pattern have the great advantages that they can be awarded very soon after the contributions in respect of them begin to be collected, and that they can be made adequate for subsistence. But, since the pension does not increase with the number of contributions paid by the individual, an incentive to contribute regularly must be supplied by reducing the benefits of irregular contributors and by keeping the insured person's share of the contribution quite low at the expense of the employer and the State. If invalidity is excluded, the administration of the scheme is very simple—much simpler than that of sickness insurance, for example. The expected

growth of industry in the coming years will mean a rising proportion of young persons in industry, and this is very favourable to the success of such a scheme.

If the State subsidy is high enough—for example, one third of the cost—the scheme may be found to be so attractive that it is largely self-enforcing, and can be applied immediately to an entire urban population, not only of wage earners, but also of their employers and of independent workers : in this way a large instalment of the social security programme can be delivered with a minimum of delay. If, however, as may be expected to be the case in most Asiatic countries, the State finds it difficult, or would be unwilling, to subsidise heavily a minority of the people, the possibility of introducing pensions of this pattern is diminished. Without a State subsidy, they are evidently of little interest to employers or independent workers, although some of the former and many of the latter may need pension insurance as much as the average wage earner. Nevertheless, a scheme providing such pensions may still be feasible for wage earners on condition that the employers pay the larger share of the contribution.

Pensions of the second pattern are much more in the nature of a saving, than of an insurance, process. Contributions are proportionate to the wage of the individual and each buys the right to a pension equal to a minute portion of that wage ; the total of the fractions becomes the pension to be paid in case of invalidity, old age or death. The building up, by this method, of pensions adequate for subsistence may take 20 years or more. Such pensions offer social security only to those who begin to contribute when young, and to them only in old age : they are altogether insufficient in the case of persons who begin to contribute when past middle age.

In practice such pensions must be supplemented by a small basic pension of the first pattern, or else a pension of minimum absolute amount must be guaranteed, a comparatively short qualifying period of two to five years being imposed as a condition for the grant of pensions with these advantages, the cost of which can be charged against the

employers' contributions, in the absence of a State subsidy. Here again, time spent under the sickness insurance scheme may be counted towards the qualifying period. The basic pension has to be so low that the total pension after 40 years of insurance will not more than suffice to meet the reasonable needs of the beneficiary. The guaranteed minimum pension will be extremely costly in the early years of operation of the scheme if it is to be adequate for subsistence. The contributory increments are vulnerable to the depreciation, slow or fast, of currencies which the world has experienced in the last few decades and which may continue in the future.

In the provision made for invalids under the pension insurance scheme, the emphasis should be on rehabilitation, just as has been proposed in connection with permanent incapacity due to employment injury. As far as possible, handicapped persons are to be rendered and kept self supporting—by specialised care, training and placement, and by an obligation laid on undertakings of a certain size to employ a quota of such persons at work which they are fitted to do.

The existing institutions—workmen's compensation, maternity benefit, provident funds—may be left undisturbed pending the development of a rational system of social insurance. They do not cover satisfactorily the risks in respect of which they provide benefits, but they are at least partially effective, and they operate with a minimum of administrative machinery, and in any part of the country.

When pension insurance is introduced and applied to workers in undertakings where provident funds exist, there will arise the problems of the relation of an insured person's credit in a provident fund to his pension right under the new scheme, and of the relation of the contributions payable to the provident fund to those payable under the new scheme. These problems have to be solved by the pension insurance law. Clearly, whether the pensions are of the first or the second pattern, the employer and the worker must be allowed to deduct their contributions under the new scheme from those which are prescribed for the

provident fund. Again, where the pensions are of the second pattern, the whole or a part of the sum credited to the worker in the provident fund can be converted into pension rights in course of acquisition under the new scheme. Where, on the other hand, the pensions are of the first pattern, the worker's existing credit with the provident fund need not be affected, if the fund continues to operate with reduced contributions ; but if the fund is wound up, the question of converting these credits into annuities would nevertheless have to be considered.

CHAPTER VI

DEVELOPMENT OF MEDICAL CARE SERVICES

The Medical Care Recommendation, adopted by the International Labour Conference at Philadelphia in 1944, provides for two alternative methods of extending medical care to the whole population: social insurance and public service. Under social insurance, every insured contributor is entitled, in virtue of his contribution, to medical care for himself and his dependants from the insurance medical service; adults whose income is below the subsistence level and their dependants are entitled to care on the same footing as insured persons, the contribution being paid on their behalf out of public funds. Under a public medical care service, every member of the community is entitled to care from the service, without contribution or other qualifying conditions ; the entire service is financed out of public funds, either from general revenue or by a special tax. The second form—a public service available to all without contribution conditions—lends itself to a complete integration with general health services, such as those for maternity and child welfare, inoculation, health education, and the like. The Conference may wish to consider which of these two forms, insurance or public service, is the more appropriate to conditions in Asiatic countries.

In view of the different nature of the problems involved, separate consideration is given to the organisation of medical care for the rural and the urban population.

Rural Population

The Problem in General

Most of the countries represented at the Preparatory Asiatic Conference are predominantly rural : in China, for

example, it is estimated that between 71 and 85 per cent. of the population are to be found in rural areas ; in India, the proportion was 87.2 per cent. in 1941 ; the 1931 figures for Ceylon, Indo-China, and Indonesia showed percentages of 84.8 (including 12.8 on estates), 90 to 95, and 92.5, respectively. These rural areas, however, are often densely populated : as a rule, the population is not, as in many western countries, dispersed over wide areas in scattered farms, but lives mostly in small, but compact agglomerations of the size of villages or small towns, connected with each other by mud roads or bullock tracks. In some countries, such as Ceylon and Malaya, the villages often lie along the main highways, and in Siam along rivers and canals, but scattered farms are not infrequently encountered. Large plantations employing labour living on the estate are, in some parts, of considerable importance.

The eastern village, usually consisting of small houses built of earth or bricks and somtimes timber, does not offer the same possibilities for the collective provision of medical care, environmental hygiene, and general health care as a large city. Nevertheless, it does offer certain facilities for health organisation which are not to be found in sparsely settled agricultural districts with scattered farms, more particularly if it acts in conjunction with neighbouring villages. First, sanitary engineering on a small scale is less costly than for scattered farms, and would benefit the whole closely knit community. Secondly, any general health and medical care services centred in the village would be available to the whole community at a minimum distance. Thirdly, the organisation of an ambulance service for conveying patients to hospitals or health centres located in towns or cities could be based on villages rather than scattered farms and would therefore be both simpler and less expensive. Technically, the structure of these densely populated rural areas would thus favour a collective organisation of all health care, based on villages as primary units and on areas comprising several villages and one town as secondary units.

Such an organisation, as attempted in China, Ceylon, the French Establishments in India, and Indo-China, and

proposed by the Bhore Committee[1] in India, might consist of a network of health centres in villages, linked up with hospitals in small towns or large villages, chosen in relation to base, or central, hospitals in the cities. It could be integrated or co-ordinated with the organisation of general health care and, to some extent, with that of environmental hygiene, since general health care could be provided at or from the centres where medical care is given.

Even a cursory survey of existing conditions in the rural areas of Asiatic countries points to the conclusion that health problems should, in fact, be treated as one and indivisible. In the Indian villages the standard of sanitation is shown by the Bhore Committee's report to be very low ; water supplies are not everywhere protected from contamination ; in most villages no system of collection and disposal of night soil exists ; and no attempt has, on the whole, been made for the collection and disposal of household refuse. Similar conditions are found in China and certain other Asiatic areas.

The inadequacy of existing medical care and general health services has also been pointed out.

In China, only 13,111 doctors were registered with the health administration in 1945 for a population of some 422,000,000, or one doctor for 30,000 of population ; there was one dentist for every 1,200,000 of population, one nurse for 70,000, one midwife for 81,000, and one pharmacist or assistant pharmacist for 81,000. In 1944, 398 hospitals were equipped with 33,384 beds, and 938 district health centres provided 5,450 beds, making a total of 0.092 beds per 1,000 of population. Some 100,000 " old style " medical practitioners, however, are estimated to be practising in China.

In India (where there are similarly a number of old-style practitioners), the most recent statistics show one doctor to every 6,300 of the population, one nurse to 43,000, one midwife to 60,000, one qualified dentist to 300,000, one health

[1] The Health Survey and Development Committee was appointed in 1943 by the Indian Government, under the chairmanship of Sir Joseph Bhore, to study health conditions and make recommendations for future development. It issued its report in 1946.

visitor to 400,000, and one qualified pharmacist (not including compounders) to 4,000,000 of the population The average rural population served by one medical institution varies from 22,904 in Sind to 105,626 in the United Provinces. Moreover the time devoted to patients at dispensaries is, according to the Bhore Committee, "so short as to make it perfectly obvious that no adequate medical service was given to the people". In one dispensary visited by the Committee the average number of cases seen in an hour was 75, and the time given to a patient therefore averaged 48 seconds. The Committee's report emphasises the importance of training staff and constructing hospitals and health centres; the final aim proposed is the provision of 5.67 beds per 1,000 of population, instead of 0.24 as at present; under its programme the number of doctors will be 233,630 as against 47,500 at the present time, that of nurses will be 670,000 instead of 7,500, that of midwives 112,500 instead of 5,000, and that of pharmacists will be 77,880 instead of 75. In Bombay province the Government intends to improve district hospitals, providing each district with a minimum of 75 general beds, to appoint honorary physicians at a monthly honorarium of 150 rupees, and to train laboratory and X-ray technicians for hospital out-patient departments. Medical schools are to be converted into medical colleges, and the qualifications required from doctors will be standardised. Facilities for training nurses are being extended by the opening of new training centres and the establishment of preliminary training schools.

In Siam, 50 general hospitals with 4,435 beds provide for a population of some 18 million, the ratio being 0.25 beds per 1,000 persons; 37 provinces are still without hospitals. In addition, however, there are 12 special hospitals, 85 municipal or Government " first class " health centres, with a qualified doctor, a sanitary inspector, a public health nurse and medical assistants, 451 second class centres, usually staffed with a medical assistant and a midwife, and 5 mobile units, 3 special units for yaws, 10 units for infectious diseases and malaria sections in five divisions. There are 1,103 qualified medical practitioners, 1,193 nurses trained in

midwifery and 584 "second class" midwives. The number of sanitary inspectors is 74, that of medical assistants 757.

In Burma, 300 hospitals with some 8,000 beds cater for a population of 16 million, the number of beds per 1,000 of population being 0.5.

Conditions are more favourable in Ceylon, where 145 general and 13 special hospitals, and 97 estate hospitals provide for a population of 6,634,000, the number of beds being roughly 2.7 per 1,000 of population. In addition, there are 250 central dispensaries in charge of apothecaries, 188 branch dispensaries, 427 visiting stations, and some 722 estate dispensaries. Even so, the Commission on Social Services finds that there is serious overcrowding of hospitals, and a lack of staff and equipment, and that out-patient treatment is frequently given by an apothecary rather than a qualified doctor. At the beginning of 1947, there were 1,033 registered medical practitioners and 49 dental practitioners. Of these, 551 were in Government service, 435 being actually engaged in medical practice; thus, the ratio of practitioners to population was approximately one for every 7,000 of population. There were 545 apothecaries, 818 nurses, 1,648 midwives and 787 pharmacists.

In the Malayan Union, the Government maintains 63 general and district hospitals, in addition to the special institutions for lepers, mental cases, and infectious diseases. The number of beds available for civilian patients in the general and district hospitals at the end of 1946 was 13,375, for a population of just under 5 million, or about 2.7 beds per 1,000. In addition, there are fixed dispensaries in most small towns and travelling dispensaries for rural areas. The river dispensaries used extensively before the war in certain regions are being restored. The number of attendances at out-patient departments and dispensaries is greater than before the war, and during the nine months April to December 1946 totalled nearly 2 1|4 million, including 600,000 at travelling dispensaries. The estate hospitals functioning at the end of 1946 numbered 156, with 6,423 beds.

In Singapore, where rehabilitation of the health services has made similar progress, some 2,400 beds were available

at the end of 1946 for a population of 950,000, or 2.5 beds per 1,000 persons. The strain on out-patient departments, however, has been increased by the shortage of staff, due to enemy occupation during the war; from April to December 1946, 164,688 attendances were recorded, as compared with 87,447 in 1938. Early in 1947, only two general hospital out-patient departments, one general urban dispensary, and a rural travelling dispensary were available to the adult population. Municipal clinics and most rural clinics dealt with children under 2 years only, and the school medical service had one clinic.

These often inadequate health services are faced by an overwhelming task. Diseases, largely preventable, are widespread. In China, over one third of the whole population, or 150 million persons, are estimated to suffer from trachoma; the number of lepers is estimated at 1 million. In India, the number of deaths due to cholera in the province of Bihar alone in the five years 1940 to 1944 has been estimated at over a million.[1] The Bhore Report, however, gives an annual average of 144,924 for the 10 years 1932 to 1941. At least 100 million individuals are believed to suffer from malaria every year and this disease is indirectly responsible, through lowering of resistance to other diseases, for 25 to 75 million cases of illness a year. In Siam, the death rate from malaria is over 8 per 10,000 of population. In Ceylon, with a population of over 6 million, 103,167 cases of malaria were treated as in-patients and 2,338,403 as out-patients in 1945. The probable death rate per 100,000 of population from tuberculosis of all forms in the Far and Middle East has been estimated by the United States Public Health Service[2] at under 100 in Ceylon, Palestine, and Syria, at 100 to 199 in Formosa, Indonesia (Java, Sumatra, and the Outer Provinces), Iraq, Kwantung, Siam, and Turkey; at 200 to

[1] Cf. C. A. BOZMAN: "Health Conditions in India in 1944", in *Indian Health Gazette*, No. 2, April 1946, p. 1.

[2] Sarah E. YELTON: "*Tuberculosis Throughout the World*", I; "The Pre-War Distribution of Tuberculosis throughout the World" (Public Health Reports, Vol. 61, No. 31, 2 Aug. 1946, p. 1145). The 1945 figure for Ceylon was 57 per 100,000 but a recent survey conducted in a suburb of Colombo showed that the rate can rise as high as 470 per 100,000.

299 in Aden, Burma, Indo-China, Japan, Korea, Malaya (former Straits Settlements), and the Philippines; and at 300 and over in China and India.

Death rates from all causes in 1937 were 22.5 per 1,000 of population in the former Straits Settlements, 22.4 in the Indian provinces (21.8 in 1943), 21.7 in Ceylon (22 in 1945), 19.9 in the former Federated Malay States, 18.8 in Java, and 17.0 in Japan, as compared with 9.4 in Australia and 9.1 in New Zealand. For China, the death rate is estimated at 25 per 1,000. Infant mortality per 1,000 live births in the Indian provinces was 162 in 1937 and 165 in 1943; corresponding rates for 1937 were 200 in China, 158 in Ceylon (140 in 1945), 156 in the former Straits Settlements[1], and 106 in Japan, as compared with 38 in Australia and 31 in New Zealand.

The average expectation of life at birth in India was 26.91 years for males in 1930-31; and 48.4 per cent. of all deaths occurred at ages under 10 years. The corresponding expectation of life in New Zealand was 65.04 years in 1931.

In view of these health and sanitary conditions, even a perfect and complete medical care service would be faced by the hopeless task of repairing damage constantly renewed, unless aided by an effective organisation of general health care aimed at preventing illness and improving the state of health, and by measures of environmental hygiene laying the foundations for a healthy community life. Collective provisions must first be made for such elementary measures as the removal of refuse and night soil, a water supply protected from contamination, the prevention of malaria by the oiling of stagnant ponds or more modern methods, the cementing or asphalting of village roads which now turn into puddles or rivulets in the rainy season, the ventilation of huts or houses to allow the smoke to escape and the air to enter, the destruction of rats and vermin, and so forth.

[1] In Singapore, the infant mortality rate was 142 in 1940, but only 90 in 1946. This decline is attributed partly to the high mortality during the war and partly to the free milk-feeding scheme and the lack of unsuitable food such as polished rice.

Similarly, the benefits of a medical care service will be largely illusory without the organisation of maternity and child welfare services and of health education for mothers. It may be appropriate to mention, in this context, the school of thought which contends that more food and satisfactory control of infectious diseases would result in a further upsurge in the rate of increase of the population, and that therefore a campaign to bring about a change in outlook, especially as regards birth control, must take precedence. Numerous investigations into population trends have shown that the birth rate decreases in those areas and in those social classes where the standard of living is rising, provided that young children are not treated as an economic asset but are kept at school by compulsory education laws. A rise in the standard of living brings a desire for greater comfort, health and personal culture, and a recognition of the dependence of these advantages on the size of the family. Other phenomena of a rising standard of living which tend to moderate the birth rate are the economic and mental emancipation of women and the sublimation of more elementary instincts in work and in cultural, economic, political and artistic pursuits. Realisation of the immense importance of health for personal and family well-being is one of the first prerequisites for the attainment of a higher standard of living that will eventually result in birth control. Even more powerful a motive may be the desire of parents, once they believe in a better economic future, to give their children a decent education in order to take advantage of that prospect. It must therefore be one of the primary tasks of any health service to further the education of mothers in regard to hygiene, more rational nutrition[1] and, in general, the methods of making the best possible use of the means at their disposal.

[1] At a Nutrition Exhibition organised by the Chief Health Officer of Delhi province in December 1945, and visited by a great number of people, suggestions were made for cheap diets for different categories of workers such as indoor workers, industrial workers, agricultural labourers, technical labourers, etc., and for diets suitable for a North Indian family. The composition of each diet was indicated as well as its cost.

Direct preventive measures such as vaccination and inoculation must also buttress the medical care service if this is not to be rendered ineffective in the face of epidemic or endemic disease.

Thus, community structure, health conditions and the general lack of health facilities in rural Asia would seem to create a strong presumption in favour of a public medical care service, for which the criteria are defined by the Medical Care Recommendation, 1944, paragraph 10, as follows : " Where the whole of the population is to be covered by the service and it is desired to integrate medical care with general health services, a public service may be appropriate."

The first step in the development of a public health service would be the training of greatly increased numbers of medical and other health personnel, without whom no care can be provided. Such training might be the responsibility of the central health authorities—federal, state or provincial, as the case may be—which would finance the training of doctors, nurses, dentists, midwives and pharmacists, on condition that they subsequently accept employment in the public health service for a minimum number of years and agree to practise in rural areas. The principles of paragraph 68 of the Medical Care Recommendation, 1944, would be applicable; it stipulates that " students of medical and dental professions should, before being admitted as fully qualified doctors or dentists to the service, be required to work as assistants at health centres or offices, especially in rural areas, under the supervision and direction of more experienced practitioners ". During a transition period, recourse might be had to the services of semi-trained staff, such as " feldschers " and " compounders ".[1] The second step would be the extension or establishment of medical

[1] In Siam, special schools have been established for training not only sanitary inspectors but also medical assistants or " dressers ", who undertake general health care at rural centres and also dispense simple medicines supplied by the Government. They take a one-year course, most of them having been male nurses in the army and navy. The number of such assistants at present in charge of the small rural health centres of the Government and the local authorities is 757 ; they are subject to the periodic supervision of provincial health officers, or assist the doctors at the larger health centres.

facilities in selected areas as outlined below[1], until, eventually, the service would have attained an adequate standard throughout the country.

A special question in the case of Asiatic countries is that of the extent to which and the manner in which practitioners of local traditional medical lore should be employed in the development of a public health service. In recent years the systematisation and modernisation of such schools of medicine has received a great deal of attention in these countries.

The Organisation of Health Services

Government Health Services.

In a number of Asiatic countries, a public medical care service already exists, if only in an early stage, and in some instances, general health care, such as maternity and child welfare, vaccination and inoculation, and health education, is combined with medical care in one and the same service.

China. The National Health Administration, which is directly under the Executive Yuan—the highest executive organisation in China—is responsible for the supervision of all health services. The Department of Medical Administration supervises local and municipal health administrations and deals with general medical practice and drugs. The Department of Health Organisation and Services is responsible for the promotion of local health services, including medical care, the training of personnel, sanitary engineering projects, and the control of food and drink and improvement of nutrition. The National Health Administration also supervises the National Institute of Health, which carries on technical research and trains public health officers. In the field of medical care, the Chinese provincial health administrations are responsible for the training of personnel, and for the provision of hospitals, special diagnostic and consultant services, and research facilities. The provincial health directors are appointed by the National Health Administration, which supervises and co-ordinates the work of the provincial health administrations, gives them technical assistance

[1] See p. 117.

and financial aid, and issues vaccines, sera, narcotics, medical supplies and equipment to all health services through its national epidemic prevention bureau, its central narcotics bureau, its central drug factory, and its surgical equipment factory.

The Chinese National Health Administration aims at establishing eventually, for the rural population, a complete health service based on districts ("hsiens"), providing both general health and medical care, and available free of charge to the population. There is to be one health worker to each group of 100 householders, and one out-patient health centre in each town or village. Each district will have a hospital-health centre equipped with 20-40 beds, a laboratory and a mobile clinic, and be staffed by a county (ch'u) health officer, 1 to 3 doctors, 1 or 2 public health nurses, 2 to 4 midwives, 1 or 2 pharmacists, 1 or 2 laboratory technicians, and 2 to 4 sanitary inspectors, in addition to a number of clerks and health workers. The district centre, fed by some 4 or 5 county subcentres, will be under the direct authority of the district government and under the supervision of the provincial health department. This in turn is supervised by the National Health Administration, which has been subsidising 4 district health centres since 1941 for purposes of demonstration, in addition to giving financial aid to a much larger number of minor health centres. The number of district health centres increased from 217 in 1937 to 751 in 1941 (in 13 provinces) and reached 938 in 1944. The provincial general hospitals will have some 100-200 beds, while a base hospital established in the provincial capital and attached to a medical college will have 500-1,000 beds and a complete medical centre. The health system is completed by health stations along the main highways with hospital wards and out-patient departments, where medical care and general health care are available to road workers, travellers, and inhabitants within a range of 60 miles' distance.

It should also be mentioned that under the Chinese Social Relief and Assistance Act of 29 September 1943, certain categories of persons are entitled to free medical treatment

or to maternity services, as the case may be. These categories include the physically unfit over the age of 60, children under 12, the unemployed in need, pregnant mothers, etc.[1]

India. Under the Government of India Act, 1935, the responsibility for providing medical care, including the establishment and maintenance of hospitals, clinics and asylums, as well as that for providing general health care, including medical education and sanitation, is placed on the provincial Governments. The Central Government is charged with international health obligations, control of the inter-provincial spread of disease, medical care for seamen, and a number of other special items. The Central and the provincial Governments each have a Minister of Health at the head of the medical care service and a public health officer responsible for general health care and sanitation, except in the North-West Frontier Province, Orissa, and Sind, where both services are combined under one officer. Under the chairmanship of the Minister of Health of the Central Government, a Central Advisory Board of Health, including among its members the provincial Ministers of Health and representatives of a number of Indian States, co-ordinates the health activities of the central and provincial Governments. Hospital and health centres in most provinces provide free care for the population, but accommodation is not as a rule sufficient in view of the demand.

Provincial Self-Government Acts in India determine the duties and powers of local boards, which, in rural areas, are district boards. In some provinces, local boards have been set up for parts of a district area; again, village "panchayats" (village authority) or union boards have certain health functions under the control of the district board. The local authorities have powers in respect of sanitation, control of infectious diseases, registration of vital statistics, control of food and water supplies, and regulation of housing construction. They appoint their own health officers, subject to previous approval by the provincial Government.

[1] See above, Chapter III, p. 41.

The weakness of this local organisation, in the opinion of the Bhore Committee, lies in the limited financial resources available to the health services, and in the delegation of executive power by the local authorities to an elected chairman, " who often finds himself powerless to enforce the law against vested interests, in the absence of a public opinion sufficiently strong to demand such action in the interests of the community ". Moreover, the fact that the local health officers and the provincial director of public health can only give advice to the chairman of the local authority, but cannot enforce their recommendations, helps to bring about a low level of efficiency. In Madras, these defects were remedied by vesting the executive power in health matters in the local health authorities rather than in the chairmen of municipalities, and the power of general administration in commissioners appointed by the provincial Government. The director of health services was given authority to enforce the execution of his recommendations by the local authorities. Municipalities have to set aside 30 per cent. of their revenue for health purposes, and district boards 12.5 per cent. In Bombay province, the organisation of medical care outside Bombay City is based on district hospitals owned, financed and controlled by the Government, with subsidiary Government-aided dispensaries, and supplemented by a system of subsidised medical practitioners attending to the rural population in the district. To the district hospitals are linked, for the supply of specialist care, the smaller hospitals and dispensaries of the local bodies, such as district boards and municipalities. Existing rural dispensaries give mainly out-patient care, and are equipped with a few beds for emergency cases. The doctor is aided by a compounder and two servants. The Bombay Government's reconstruction plan provides for a considerable extension of district hospitals and the transformation of rural dispensaries into cottage hospitals, at which 2 doctors, 2 nurses, 2 compounders, 4 ward servants, 2 sweepers and a cook are employed. A subsidised medical practitioner scheme is also being developed (see p. 104).

The Bhore Committee has recommended a 40-year programme, paying special attention to the needs of rural districts and providing for the establishment of a complete free health service available to the entire population, and a 10-year programme on similar lines but limited in scope by the financial resources and trained personnel at present available. Under this plan the ministries of health are the ultimate authority for all health services within their jurisdiction. At both levels of administration, the department of health is under the direction of one administrative officer: the director-general of health services for the Central Government, and the director of health services for the province. At the local level, health services are organised on the basis of administrative districts under an officer responsible for all services in his area. A council of experts, including representatives of the medical and allied professions, provides technical advice to the Minister of Health, and district councils of experts aid the district health board, on which health authorities and the people are represented.

The 40-year programme of the Bhore Committee is based on hospital-health centres providing both medical care and general health care. The administrative district is chosen as the area for the development of the plan. The smallest unit of administration of the district health organisation is the primary unit normally serving an area with a population of 10,000 to 20,000. The primary unit has a 75-bed hospital with its own nursing staff and a health centre ; its staff consists of 6 medical officers and 6 public health nurses. The unit is utilised both for curative and for preventive health services, such as welfare of mothers and children and health of school children. A number of primary units—some 15 to 25—together constitute a secondary unit. The latter has a hospital with some 650 beds, as well as a health centre and a staff larger than that of the primary unit. Its administrative officer supervises and co-ordinates all health services in the area of the unit. At its hospital, full-time heads of different departments of

medicine, surgery, and pathology and of modern laboratories attend to their hospital duties and also inspect, periodically, similar work carried on in the primary unit hospitals. Two senior public health nurses and two senior sanitary inspectors supervise the corresponding work of the primary units. The assistant public health engineer of the secondary unit supervises all activities in connection with environmental hygiene in the area of the unit. A varying number of secondary units—3 to 5—form a district health unit. The district health centre possesses general as well as special hospitals, with a total number of some 2,500 beds and " all the consultant and laboratory services required for the diagnosis and treatment of disease on up-to-date lines ". More complicated cases are removed from primary to secondary or district hospitals. Ambulance service and telephone connections between all types of hospitals are deemed essential. At all the hospitals, social workers are employed to visit patients in order to ascertain the causes of disability and to serve as connecting links between the public and the health services. In the opinion of the Committee, the organisation will tend to become a full-time salaried service devoting itself to the health needs of the people, and the workers engaged in it should not carry on private practice. The short-term or 10-year programme of the Bhore Committee stresses the preventive side of the health organisation in view of the limited staff and funds available, and concentrates on primary and secondary units. In the opinion of the Committee, medical care should be available free to all and financed by general and local taxation; the Central Government, with its larger resources, should give financial assistance to the provincial health schemes.

The Central Government and the provincial Governments have elaborated, and begun to carry out, comprehensive five-year plans of social and economic policy. Central grants will be given to the provinces on certain conditions, the most important of which stipulates that the schemes under each head shall form part of a policy or plan approved generally by the Government of India. The expenditure proposed under the head of health services is about 990

million rupees, or roughly 12.6 per cent. of the total expenditure on all items, including irrigation, electric power, roads, pests, agriculture, industries, education, co-operation, etc. The provinces have been asked to include pilot schemes for the establishment of a district health organisation in selected areas, in accordance with the standards suggested by the Bhore Committee.

In Madras, for instance, all existing local fund and municipal medical institutions will be provincialised. A 20-year plan is designed to bring medical care and general health care within reach of every village, none of which would be more than five miles from a rural dispensary. In heavily populated areas, the population factor will be combined with the distance factor, and a centre will be provided for every 10,000-12,000 persons. Each rural dispensary will have 8 beds, including 4 maternity beds. Hospitals with 50-100 beds will be established at every local ("taluk") headquarters, with special departments for tuberculosis, leprosy, venereal diseases, and eye treatment. District hospitals will provide specialist treatment, including dental care, and will be equipped with a first-class laboratory and an X-ray department. Altogether, 1,487 new dispensaries and 177 new taluk headquarters hospitals will have to be built under the plan. Environmental hygiene and general health care will at the same time be extended and improved through the establishment of health centres staffed with health inspectors, health visitors, and midwives.

The State of Mysore has an extensive service uniting all aspects of medical and health care, and based on rural health centres at which maternity and child welfare, free out-patient care, and other services, such as anti-malaria work, are or will shortly be organised.

A scheme for bringing medical facilities more readily within reach of villages throughout the State has been drawn up by the Government of Hyderabad. Two mobile medical relief units, each estimated to cost about 300,000 rupees to furnish, and a similar amount yearly to maintain, are to be established. These units will work on the lines of regular hospitals, each having its own medical, surgical, public health, maternity and child welfare, rural sanitation, ophthal-

mic, dental, and laboratory sections in charge of specialists. They will be fully equipped and staffed, and have a capacity of 100 beds. Suitable sites will be chosen throughout the State, and at each of these a unit will camp for three or four months. It is estimated that each unit will be able to cater for the needs of people residing within a radius of 50 miles from the camp. Besides giving medical attention, the units will carry on health propaganda, give advice on sanitation and open temporary child welfare centres. The main object, it is stated, will be to bring medical aid to people in rural areas and make them health-conscious, so that they will be able to understand and take advantage of the facilities.

Siam. A health service providing both medical and general health care as well as dealing with environmental hygiene has been developed in Siam and is now placed under the Ministry of Health. The Ministry is also in charge of medical education. Government hospitals with out-patient clinics under the medical department provide free care to those who, in the opinion of the doctor at the out-patient clinic, cannot afford to pay. Some 90 per cent. of the patients are treated free of charge. Health centres, under the Public Health Department, dispense medicines and treat ambulatory cases in the more populous districts, while smaller rural centres dispense simple remedies, give first aid, and undertake general health care, such as midwifery. The Department also undertakes health education, promotes the installation of sanitary latrines, and assists the provincial authorities in fighting and preventing epidemic diseases through medical assistants and mobile units. Municipal hospitals and health centres work on parallel lines.

Burma. Before the occupation of Burma by the Japanese, the Government medical care service and the public health service were separate units. Since the resumption of civil government after the liberation, both services have been placed under the Director of Medical and Health Services. The medical service supervises all hospitals through its district medical officers, the civil surgeons, and administers the 70 Government hospitals financed entirely from Government funds. Under the Municipal and the Rural Self-Govern-

ment Acts, a statutory obligation is placed on local authorities—municipalities, rural district councils and deputy commissioner's[1] local funds—to provide hospitals and out-patient clinics in their areas. There are 175 such local hospitals and dispensaries. All Government and local authority hospitals are staffed by Government doctors, including a few Indian Medical Service officers, some 100 civil assistant surgeons with university degrees, and about 300 sub-assistant surgeons who have taken a four-year course at a Government medical school. The number of private hospitals is 35, of which 25 are subsidised by the Government; and there are 25 railway hospitals. The number of nurses is one to every 50 beds in Government hospitals, and to every 80 beds in local authority institutions. Medical care at out-patient clinics and in public wards of hospitals is available free to everyone. Public health inspectors, vaccinators and sub-assistant surgeons, epidemic mobile teams, and anti-malaria units are engaged in general health care and environmental hygiene, which are the responsibility of the Government public health service and its district health officers. In many districts, the medical officer is also *ex officio* health officer. Maternity and child welfare centres are the responsibility of local authorities; midwives and health visitors are now appointed by the Government.

Village headmen and village committees, usually elected, and subordinate to the deputy commissioner, who works with the rural district councils, are concerned with health matters on the instructions of the commissioner.

All Government and local authority health services, except sanitary engineering, are placed under the authority of the Social Services Department, which also plans rural development and housing. Local authorities use the proceeds of rates and income from public utilities for financing health services. As a result of the war, however, local resources have largely dried up, and the Government gives financial aid to the local health services drawing its funds from custom duties and land revenue.

The Government plans to set up township and village

[1] Government representative.

councils with a view to fostering the interest of the people in local affairs.

Ceylon. The Government, through the Department of Medical and Sanitary Services, provides medical care at its hospitals and clinics for all residents; in the case of immigrant labourers on estates and other labourers and their dependants employed and residing on estates, the cost is met by the employer as described below (under the head of "Employers' Liability"). Out-patient treatment at hospitals and central dispensaries is available free of charge, irrespective of the patient's income, as a public service. In-patient care in public wards is provided free of charge to persons with incomes not exceeding 50 rupees a month; persons with incomes between 50 and 83.33 rupees are charged 0.30 rupees per day, and those with incomes of 83.33 rupees or more, 0.50 rupees a day. In-patient care is thus provided on the basis of social assistance. The same Department is responsible for general health care and environmental hygiene. The Minister of Health is the political head of the Department, and is assisted by an Executive Committee consisting of seven members of the State Council. The technical head of the Department is the Director of Medical and Sanitary Services, who has two deputies, the Assistant Director of Medical Services and the Assistant Director of Sanitary Services, and a team of special officers. On the divisional level, the country has since January 1947 been subdivided into 13 districts with one divisional officer in charge of both medical care and general health care (and environmental hygiene); before 1947, the two branches had been under separate divisional heads. There are three types of Government hospitals: the central provincial hospital, staffed by specialists; the district hospital, equipped for normal cases of medicine, surgery or midwifery, but without facilities for specialist treatment; and the small rural hospital, which is now generally associated with a central dispensary. Other central dispensaries give out-patient treatment only. Maternity homes cater for normal cases of pregnancy and labour and are usually in charge of a trained midwife working under the supervision of a public health

nurse and the medical officer of health; in 1946, there were 8,316 deliveries in Government maternity homes. Special institutions for tuberculosis, mental cases, infectious diseases, etc., complete the list of medical institutions.

General health care and environmental hygiene are organised on the basis of health units under a medical health officer. The work of the health unit, based on centres separate from those at which medical care is given, includes care for mothers and children by midwives and public health nurses (who also pay home visits), health education, malaria control by the oiling of rivers and streams, entomological work at observation stations and the spraying of houses, school medical service, and the training of medical and health personnel, etc. A health unit of 50,000 people would normally have one full-time medical officer of health, 5 sanitary inspectors, 5 public health nurses and 10 midwives; special services dealing with tuberculosis, venereal disease, and leprosy are in charge of senior officers who work in co-operation with the medical officers of health and their staffs in carrying out field work.

Curative medical officers in Government service are allowed private practice, but new entrants are allowed such practice only in regard to their speciality, and provided there is no other Government medical officer with a right to private practice or a private practitioner in the area. Medical officers of health—engaged in general health care—are not permitted to engage in private practice.

The Government Medical Department works in close co-operation with the local authorities. The three municipal councils, however, are largely autonomous; they undertake general health care and out-patient care, while in-patient care is the responsibility of the Department. Other local authorities are supplied by the Department with sanitary inspectors and public health nurses from a central pool, about one half of their emoluments being paid by the local authority; the authority bears the entire cost of employing qualified midwives.

The Government of Ceylon spent 21.6 million rupees on medical services in 1944-45, or 8.5 per cent. of the total expenditure, and the estimate for 1946-47 is 34 million rupees.

Indo-China. An Inspector-General of Public Hygiene and Health, subordinate to the High Commissioner for France in Indo-China, centralises all matters relating to hygiene and medical assistance. In each of the five territories of the Federation, a general delegate of the High Commissioner is responsible for the co-ordination of the services. Each territory possesses a Board of Health, which administers the various medical and hygiene institutions, its technical staff is composed of doctors, midwives, and male and female nurses. The Faculty of Medicine of Indo-China, which was opened in 1909, has since 1934 issued diplomas equivalent to those given in France, after studies of the same duration, with the result that the management of the hospitals is by degrees coming into the hands of Indo-Chinese doctors. Similarly, the Faculty undertakes or supervises the training of Indo-Chinese midwives and of nurses. In 1937, the most recent year for which statistics have been published, these show that the medical staff of the public assistance authorities comprised in all, for a population of 20 million, 240 Indo-Chinese doctors, 110 European doctors, 330 Indo-Chinese midwives, 1,600 civilian Indo-Chinese nurses (male and female), 50 religious nursing sisters, and 50 European nurses (male and female), in addition to 2,000 auxiliary staff. As regards the number of institutions in existence, in addition to the maternity hospitals and hospitals of Hanoi and Saigon[1], there were in 1945, before the damage caused by the Japanese occupation and the subsequent fighting, one hospital at the capital of each of the 88 provinces, one maternity home at the centre of each district, and rural first-aid posts under a male nurse and a midwife. At all these, out-patient care is available. The rural posts serve as centres for the tours undertaken by the nurses for the purpose of ascertaining cases of sickness and those periodically undertaken by the doctors of the public health service in rural areas.

All out-patient care given by the public assistance services is free of charge, as also in-patient care in the public

[1] Some of these are specialised, such as the Ophthalmological Institute at Hanoi.

wards of the hospitals and maternity homes; no means test is required. As an inducement, however, to the less well-to-do members of the middle classes to have themselves treated, the public health authorities were led some 12 years ago to institute a system of fee-charging consultations and to open paying wards in the hospitals in the larger towns. The fee charged is very small and does not cover the costs; it serves merely as a means of selection among patients which meets the wishes of certain sections of the population.

Curative and preventive action against sickness and epidemics (by vaccination, etc.) is usually undertaken jointly by the public hygiene and health services. There is a system of medical inspection of school children in the larger towns, most of which also possess municipal hygiene services. The Pasteur Institute pays special attention to fighting social diseases; and its malariological service directs or supervises all measures for the prevention of malaria. In particular, it must approve of the measures that the plantations are required to adopt for this purpose. A considerable amount of work has already been undertaken, especially for the drainage of polluted waters, which was financed out of a loan issued in 1931, the costs of maintenance being met out of the general budget. A substantial degree of success was recorded before the war; for example, the malaria index of Haghiang in Tonkin declined from 80 to 17 per cent. The Pasteur Institute also combats epidemics by the large-scale supply of vaccines (in the last cholera epidemic, for instance, 17 million ampoules were provided in the course of a few weeks).

French Establishments in India. The organisation of the public health services is based on the same principles as those applicable in Indo-China, but the results attained are proportionately greater since, for a population of only 300,000, there are a general hospital in Pondicherry, cottage hospitals with maternity wards in the other four territories, and 15 rural dispensaries. The aggregate staff consists of 32 Indian doctors or health officers, 5 European doctors, 15 midwives, and a corps of male and female nurses. In addition, there are a public pharmacist and two veterinary surgeons. All treatment is given free of charge.

Malaya. The Malayan Union has a well-developed health service which is now vested in the Central Government, under the Director of Medical Services, although still administered by medical officers of the States forming the Union. As, in Burma, Ceylon, and Singapore, medical care, general health care and environmental hygiene are organised as one service. Some municipal areas have their own health services undertaking maternity and child welfare and environmental hygiene, but medical care is provided by the Government service only.

Medical care is available free at out-patient departments of hospitals and dispensaries to the whole population except workers on estates, who receive care in the event of minor injuries or conditions at the plantation (see page 96). As to in-patient care in public wards, employers of plantation labour and other large employers who send their workers to hospital, usually on the recommendation of a private doctor engaged by the employer to treat his workers, are under a legal obligation to pay a fee towards the hospitalisation of their workers. Otherwise, there is no means test, and it is left to the medical officer in charge to decide whether or not the patient can pay; generally, care in third-class wards is given free of charge.

Urban and rural hospitals, with out-patient departments, are supplemented by permanent health centres staffed with a nurse, a midwife, a health inspector and a dispenser, and visited from time to time by a doctor. Travelling clinics with a nurse, a dresser or doctor, pay weekly visits to places not otherwise provided for. Maternity and child welfare and care for mothers and children up to school age is undertaken from large centres in cities, staffed with a lady doctor, nurses, trained midwives, dressers, dispensers and clerks, whose doctors visit outlying clinics and whose public health nurses visit village clinics, homes with babies, schools, and other places where mothers and children forgather. At the Kuala Lumpur Infant Welfare Clinic, the average daily attendance is 200 (62,000 per year); in 1946, 225 districts were visited and 21,660 cases attended. Dental care is given free at some 20 clinics to schoolchildren and

children of pre-school age who cannot afford a private doctor, and to certain specified groups of persons Expectant mothers, patients at Government hospitals or clinics who need dental care and cannot afford private care, and other persons earning not more than $M.100 a month are admitted, but pay a fee unless specially exempted.

The tendency is to establish complete health units with emphasis on the preventive side. Health officers deal with environmental hygiene, including anti-malaria control.

Singapore. All health services in Singapore are united in one Department, under the Director of Medical Services. The two officers in charge of medical care, on the one hand, and of general health care and environmental hygiene, on the other, discuss health policy in regular meetings with the Director. Medical care, both at out-patient departments and centres and in third-class wards, is given free of charge, without a means test, but in-patients are expected to make a voluntary contribution if they can afford it. The introduction of a means test is under consideration, in view of the overcrowding and shortage of accommodation in hospitals. Venereal disease is treated at a special hospital, which has proved a great success. There are no Government dental services at present.

Maternity and child welfare under the public health matron, is provided in rural areas at 9 centres, which are staffed with a resident nurse, a midwife, and an attendant and 3 subcentres with a resident midwife and attendant. In addition, weekly clinics are held in other districts, on such premises as are available. There is a constant and enthusiastic demand for this work, and the local population has offered to collect funds to build three up-to-date centres. Breast-feeding is encouraged, and the results have been remarkable; free milk in powder form is provided free to expectant and nursing mothers, motherless infants, and children aged 1 to 4 years. In the period April to December 1946 attendances of infants under one year numbered 39,096, those of children over one year 45,309, antenatal attendances 8,983; 3,317 confinements were attended to, followed by 20,339 nursing visits; home visits to infants

up to 40 days numbered 28,563. In Singapore city, maternity and child welfare are the responsibility of the municipality.

The Department also undertakes anti-malaria work, school medical inspection, port health work, vaccination and inoculation, medical education, and sanitation. Child feeding has also been undertaken by a Child Feeding Committee, supplemented for the 2-6 year group by the Social Welfare Department[1].

The total expenditure for the nine months from April to December 1946 was just over $S.4,500,000. Plans have been worked out for a considerable extension of health services, to be achieved in stages. The programme includes among other items the building and enlargement of hospitals, outpatient clinics and health centres, anti-malarial and drainage work, water supply, organisation of school medical and dental services, and better accommodation for the staff.

Employers' Liability.

In a number of Asiatic countries, the owners of large estates, chiefly plantations, are liable to provide medical care, and sometimes general health care, for all or certain groups of their employees.

In Malaya, for instance, the superintendents of estates maintain hospitals for their workpeople under the supervision of the Government, whose medical officers inspect the hospitals with a view to ensuring an adequate standard of efficiency. The larger estates have hospitals of their own; the smaller ones frequently maintain hospitals for a number of properties in common. According to the Labour Adviser to the Secretary of State for the Colonies, this system of collectively organised services might admit of some extension, since increasing availability of motor transport enables patients to be sent over longer distances in reasonable com-

[1] The Social Welfare Department has greatly contributed to the improvement of the health of children and of nutrition for adults by providing free meals for children under 6 years and establishing popular restaurants where nourishing meals are provided at 8 cents, or, for the middle class, at 35 cents a meal. These restaurants have been self-supporting, and have brought down black market prices of rice and other foodstuffs by up to two thirds; they have also spread the habit of diets more nourishing than the traditional polished rice and condiment diet among the Malayan population.

fort. The reluctance of the labourer to be taken far from his family must, however, be recognised. Before the Japanese invasion, the largest estates had well-equipped hospitals with modern wards and qualified staff, including midwives; the smaller, privately owned estates, however, sometimes have very limited medical facilities. In the former Straits Settlements, estate employers must provide medical care, including the supply of medicines and hospitalisation, for all Asiatic labourers and their dependants residing on the estate. The employer bears the expense of hospital maintenance and care but may recover a prescribed percentage from the labourer under contract who has received, or whose dependants have received, care and maintenance in hospital. Such care may be given either in a hospital maintained by the estate or in a Government hospital. The Commissioner for Labour appointed by the Governor may order any estate employer to construct and maintain a hospital and employ a medical practitioner.

In Ceylon, medical care for immigrant labourers and other labourers employed and resident on specified types of estates, as well as for their dependants, must be provided by the employer under the supervision of, and with assistance from, suitable agencies and officers of the Government. The estate superintendent may provide medical care of a standard satisfactory to the district medical officer, or he may make use of the Government facilities described above, in return for the payment of prescribed fees for the visits of medical officers or for hospitalisation at Government institutions. Government medical officers must visit sick persons on estates and give directions as to their care, and also inspect and report to the Director of Medical and Sanitary Services on conditions in estate hospitals and clinics. The Services provide drugs of limited value free to such hospitals and clinics. These must be erected and maintained in accordance with rules laid down by the Government concerning the building site, the provision of bedding, diet, and other matters. A Medical Wants Committee advises the Government on matters relating to the administration of these provisions, the cost being met from the proceeds

of an export tax on tea, rubber, and cocoa. Employers may claim a rebate of export duties if the estate has a hospital or dispensary of its own.

Similarly, in Indo-China, every labourer under contract is entitled, for himself and his dependants, to free medical care, including the supply of medicine, at the employer's expense. The patient must be placed in the infirmary of the estate, or, if seriously ill, taken to a local government hospital, unless the estate has accommodation considered adequate by the health authorities. The employer pays the local treasury for hospital care and maintenance given to his employees at a rate fixed by the local authorities. If there is a risk of malaria, the employer must issue quinine to the workers according to the doses prescribed by the Board of Health, and he must take any other measures required by the Board in accordance with the recommendations of the malariological service of the Pasteur Institute. If he does not carry out these obligations himself, they are undertaken at his expense by the Board of Health. In Cochin-China special regulations provide that undertakings with less than 50 labourers must have a first-aid post, and those with 50 labourers or more an infirmary and one or more hospital wards with bed accommodation for 6 per cent. of the workers employed on the estate. For 300 labourers, there must be one hospital attendant, whose work is supervised by a doctor paying periodical visits to the infirmary. On discharge from hospital, the worker is given a medical examination and the doctor decides whether he can carry on with his usual work or whether he should be employed on lighter work or repatriated. Ambulance services must be provided by the employer, the larger estates being required to keep a car for this purpose. The health authorities may at any time order the distribution of quinine, vaccination or a free supply of hot tea or rice-water to some or all of the labourers on an estate. Free labour employed on the plantations is similarly entitled to medical care in the event of accident and sickness directly caused by the employment. In Cambodia, the employer of 6,000 labourers or more must provide one French doctor, and the employer of more than 12,000 workers two doctors.

In Indonesia (former Outer Provinces), the principle of employer's liability for providing medical care was first introduced in 1915 on the east coast of Sumatra. Previous legislation for the various provinces was consolidated in the Coolie Ordinance of 1931, which governed the employment of immigrant labour—largely from Java—under long-term contracts providing for penal sanctions in case of non-compliance. These contract workers, whether employed in large-scale agriculture or in industrial, commercial, railway or tramway establishments, were entitled, in case of illness, to hospital care and maintenance, including necessary medicines and dressings, for themselves and the members of their families, at the employer's expense. A worker, or a member of the worker's family, receiving hospital care was entitled to a full diet of prepared food. When a worker was hospitalised, his family received food free of charge from the employer. The worker had to be placed in hospital at a reasonable distance from the place of employment. Transport to and from the hospital or clinic was provided free. Women were entitled to maternity rest with pay during the last 30 days before and the first 40 days after childbirth. With the gradual abolition of contract labour and the repeal of the Coolie Ordinance in 1941, these provisions ceased to apply, but draft Immigrant Labour Regulations, imposing similar duties on the employers of free immigrant labour in the Outer Provinces, were submitted to the Volksraad in 1942. The war and subsequent events have so far postponed their discussion and implementation. Before the war, employers of free labour had certain, less extensive, obligations regarding the provision of medical care, under an Ordinance of 1911.

Conclusions.

The existing organisation of health services in Asiatic countries, as will be seen from the preceding paragraphs, as well as informed official and expert opinion, would appear to favour a combination of all health services in one organisation. Such organisation would be based on hospitals and health centres under the supervision of provincial, federal or State authorities, as the case may be, but would

rely upon local co-operation of the people for its day-to-day administration. "No permanent improvement of the public health can be achieved", the Bhore Committee in India maintained, "unless the active participation of the people in the local health programme is secured."[1]

In fact, paragraph 34 of the Medical Care Recommendation, 1944, stipulates that, "where no adequate facilities exist or where a system of hospitals with out-patient departments for general-practitioner and specialist treatment already obtains in the health area at the time when the medical care service is introduced, hospitals may appropriately be established as, or developed into, centres providing all kinds of in- and out-patient care and complemented by local outposts for general-practitioner care and for auxiliary services".

These medical care services would be combined with general health services, in accordance with paragraphs 44 and 45 of the Recommendation "by establishing common centres as headquarters for all or most health services". The doctors, nurses and other staff participating in the medical care service and working at health centres would "undertake such general health care as can with advantage be given by the same staff, including immunisation, examination of school children and other groups, advice to expectant mothers and mothers with infants and other care of a like nature".

The local administration of medical care and general health services should be unified or co-ordinated within areas formed for the purpose and sufficiently large for a self-contained and well-balanced service by one area authority. Such administration should be carried out by or with the advice of bodies representative of the beneficiaries, and partly composed of, or assisted by, representatives of the medical and allied professions, so as to secure the technical efficiency of the service and the professional freedom of the particulars doctors (Medical Care Recommendation, 1944, paragraphs 24, 104 and 105).

[1] *Report of the Health Survey and Development Committee, op. cit.*, Vol. IV, pp. 13-14. Each village should, according to the Committee, have a health committee of voluntary members taking an active part in the administration of health services.

The view expressed by the Bhore Committee that a salaried medical staff would appear the most appropriate solution in an Indian public health service covering the whole population is in accord with the provisions of the Recommendation: paragraph 57 stipulates that doctors and dentists working for a medical care service covering the whole population may appropriately be employed whole time for a salary, with adequate provision for leave, sickness, old age and death, if the medical profession is adequately represented on the employing body Similarly, according to paragraph 61, members of allied professions rendering personal care, such as nurses, health workers, compounders and midwives, should be employed whole time for salary.

Health work at village centres might, with advantage, be combined with work for the improvement of rural conditions in general, much on the lines of the work of the Rural Reconstruction Department created by the Government of the Punjab in 1933 and of the rural welfare centres in Egypt.

According to the report on its work during the period April 1940-June 1944, the Punjab Rural Reconstruction Department co-ordinates the work of different departments and promotes, through propaganda and otherwise, such health measures as vaccination, control of mosquitoes, ventilation, village sanitation, and agricultural improvement through the conservation of manure, the distribution of good seeds and the popularisation of newer and better crops, the fighting of insect pests and plant diseases, livestock breeding, the organisation of the sale of milk and ghee in towns, afforestation and improvement of grazing areas, as well as the encouragement of cottage industries and education of girls. The work is done by means of films, plays, records, pictures, exhibitions, competitions, etc. Village welfare workers are trained by the Department and posted in villages, where they maintain a model house and instruct women in household management, special welfare and home craft, sewing and knitting, reading and writing. "Experience has shown that unless such help [from village women] was forthcoming the male population of the village could not achieve any remarkable results."

The Fellah Department in Egypt has created rural welfare centres and rural reconstruction societies for villages, under the supervision of the Department, which also extends financial aid to the societies. Reclaimed land is also distributed free. Each centre has three resident employees who study the people's needs and try to organise the local people. There is, first, the social worker, a graduate of the Faculty of Agriculture, who aims at raising the fellah's standard of living by introducing new methods of agriculture, selecting the best seeds, helping the farmer to market his products, developing co-operation, introducing new crops and cottage industries which permit the fellah to earn a subsidiary income, etc. He also settles disputes and organises charity, and, with the help of the people themselves, supervises the hygiene and sanitation of the village. A full-time medical doctor gives a physical examination to each inhabitant and makes a complete medical survey. He instructs villagers in hygiene and prophylactic measures, treats the sick and distributes medicine free. He also undertakes minor operations, while major cases are transferred to the Government hospital. His task further includes the inspection of food in the local markets and, generally, the supervision of health conditions in the village. A qualified health visitor, with training in social service, attends to pregnant women and babies, teaches women cottage industries, dressmaking and the like, visits village schools to instruct children in hygiene and cleanliness, and regularly visits each house in the village and teaches and demonstrates household hygiene.

Financial Aspects

Distribution of Wealth.

Community structure, health conditions, and the type of existing health facilities in rural Asia have been found to favour a unified health service providing both medical care and general health care for the rural population. How, in practice, could an adequate service of this kind, and more particularly the medical care part of the service, be financed ? The *per capita* income in most Asiatic countries is very low, especially for the rural population. In China, for instance, the average annual income per head

of the agricultural population in the period 1929-1934 was 73 Chinese dollars, as against 416 dollars per head of the population engaged in modern industry. These figures, however, do not represent money income; in fact, a considerable part of the output in agriculture is consumed directly by the family of the farmer; a part, if he is a tenant, goes to the landlord; and a part to the tax collector, either in cash or in kind. An enquiry in China showed that on the average as much as half of the harvest was paid in rent to the landowner.

Indebtedness has been very extensive, moreover; much of the available cash income of the farmer has gone to the moneylender. Thus, in 1933 at least 50 per cent. of the farmers in China were estimated to be in debt. It may therefore be assumed that the income of the vast majority of the rural population has not exceeded the subsistence level and their money income has been very low indeed. For the present, however, the situation of the farmers has been greatly eased by the currency inflation, which has enabled them to pay off most of their debts. In India, rural income in 1931-32 was only 48 rupees per year per head, as compared with an urban income of 162 rupees. In Ceylon, an economic survey revealed that in 8 districts an average of 73 per cent. of the rural families were in debt (percentage varying from 57 to 100).

The Medical Care Recommendation, 1944, provides that under a social insurance medical care service persons whose income does not exceed the subsistence level should not be required to pay an insurance contribution; equitable contributions should be paid by the public authorities on their behalf or, in the case of employed persons, wholly or partly by their employer. In most Asiatic countries the majority of the rural population would fall within this group of persons for whom contributions would be payable by others. The complicated mechanism of insurance would therefore appear inappropriate in these countries. Social assistance granted on the basis of a means test, on the other hand, would involve enquiries into the means of each applicant; but since it is known that the majority of the population would

satisfy the means test, this would be redundant for all practical purposes.

A public service available without contribution conditions or means test and financed out of public funds would therefore appear the most reasonable solution.

Possible Financial Resources.

The next question, however, is how to raise the funds required to finance such a service, in view of the generally low income of the Asiatic countries. The funds at present available for financing general health and medical care services have as a rule proved insufficient for the maintenance of an adequate standard of efficiency, and supplementary resources must therefore be found if health services are to be gradually improved and extended. The Bhore Committee recommended that every municipality in India should earmark not less than 30 per cent. of its income from all sources other than Government grants for expenditure on medical and general health care, and every district board or panchayat not less than 12.5 per cent. of its income, and that Governments should be obliged to spend not less than 15 per cent. of their revenues on health activities. The cost of the short-term programme is estimated at 1 rupee 13 annas per head per year. In Bombay province, a scheme has been introduced under which medical practitioners are subsidised by the Government on condition that they practise in rural areas. Each subsidised medical practitioner regularly visits three or four villages on definite days of the week. Early in 1945, 333 such centres had been sanctioned by the Government and more are to be established. The reconstruction schemes of the Government of Bombay moreover provide for the improvement of district headquarters hospitals at a cost of 1,600,000 rupees. The total cost of the new health schemes is estimated at 6,036,000 rupees capital expenditure and 3,754,000 rupees recurring annual expenditure. These plans, as also those in China, provide for the financing of medical care services out of general revenue. It might, however, be well to set aside some special source of income for meeting the expenses of medical care, and these expenses only.

Some indication of the possible sources may be obtained from the fact that a high proportion of the national income appears to be concentrated in a few hands only. In India, for example, one third of the national income is estimated to be shared by not more than 5 per cent. of the population: according to an estimate published in 1924, out of a total population of 320 million, there were at one end of the scale 30,000 persons (including 6,000 earners supported by incomes of 100,000 rupees a year, and at the other, some 200 million people supported by incomes of 50 rupees a year. In Ceylon, in 1935, 78.16 per cent. of the incomes of residents were below 25 rupees a month, 92 per cent. below 50 rupees, and 97 per cent. below 100 rupees; the landowner's share in the crops varies generally from one half to one sixth of the yield. In China, 75 per cent. of all peasants work on farms of less than 4.9 acres, 92 per cent. on farms of less than 8.65 acres.

Those in whose hands a great part of the national wealth is concentrated might thus be called on for the raising of special funds. As regards the rural population, the owners of large estates employing agricultural labour, and those whose estates are cultivated by tenants, might be required to pay a share of the cost of medical care services in their region. It may be recalled that, in a number of countries, the owners of estates are in fact at present liable to provide medical care for their labourers. The health tax collected from these landowners might be based on the area cultivated, having regard to its quality, or on the total net income derived from the estate. Care should be taken that this tax is not transferred to the labourer or tenant, directly or indirectly, and that it is raised in the form of a tax on income.

Smallholders, that is landowners not employing labourers on their land or leasing their land to tenants, might be asked to contribute a small tax. This tax might be a percentage added to the land tax, where such a tax is payable, or could be based on the area cultivated and the size of the family, as well as on the nature of the crops, being made to depend on the area per head of family not employed

otherwise than on the farm, so as to take account of the number of people whom the farm has to feed. The nature of the crop is evidently of great importance in this connection. If the area per head of family falls below a minimum deemed sufficient only for subsistence, no tax should be charged, as stipulated in paragraph 89 of the Medical Care Recommendation, 1944. Generally, in Asiatic countries farms are small; in China, moreover, it has been found that the size of the family tends to increase with that of the farm. An enquiry into the conditions in two Chinese villages showed that the farms yielded an income which, after payment of rent and the home-consumption of rice, left a margin quite insufficient to cover other necessary expenses.

The health tax so raised together with that collected from persons residing in rural areas other than farmers, would go towards the financing of the medical care services administered centrally by the Government, and locally by officers of the health authorities with the assistance of representatives of beneficiaries and the advice of professional bodies. To the proceeds of the health tax would be added a contribution out of general revenue towards the expenses of central administration and general health care. This contribution would be at least equivalent to the one now granted and would have to be gradually increased as health services developed and the national income rose as a result of improved methods of farming, through irrigation, the use of tractors and motorised transport, co-operative or collective farming, and the like.

Consideration might be given to the possibility of stimulating the interest of the people in the medical care service, and of encouraging self-help, by raising a very low contribution from all villagers, including tenants and labourers as well as tradesmen, whose income rises above a prescribed level, to be fixed by the responsible authorities, which would take account of actual conditions in each area.

It might be advisable for the State to raise special funds for financing the building and equipment of hospitals, and the establishment of health centres in those areas in which

a health tax on income cannot be raised according to the suggestions made above in conformity with paragraph 91 of the Medical Care Recommendation, 1944.

Urban and Industrial Population

The Problem in General

Health conditions and their counterpart, health facilities, although better in some urban areas than in many rural parts of Asia, nevertheless fall far short of adequate standards in the majority of cases. Moreover, a number of factors aggravate the health situation in towns as compared with that in the country. One of these is housing, particularly among industrial workers. Figures quoted by the Bhore Committee for India point to excessive overcrowding, both among industrial workers and in the urban population in general. In 1938, 74 per cent. of the population of Bombay, 62 per cent. of the families of Cawnpore, and 63 per cent. of those of Lucknow lived in one-room tenements. In Bombay, such tenements constituted 84 per cent. of all tenements. In Bengal, at the beginning of the war, 150,000 workers in the Calcutta-Howrah area lived in 4,000 one-room tenements. The Committee, describing housing conditions in Calcutta "bustees" and in Cawnpore "ahatas", stated that as many as 8 or 10 persons not infrequently live in one dark, dingy room of about 10 by 8 square feet, which neither air nor light can enter. "Washing and bathing facilities are often non-existent." In some cases, however, employers have provided their workers with better housing conditions. Overcrowding is also known to be severe in Chinese and other Asiatic cities and towns. In Ceylon, however, urban conditions are in general more satisfactory than in the other Asiatic countries under review, with the possible exception of Malaya.

In China, the effects of the Japanese occupation and the present housing shortage have together led to increased adoption of the system of dormitories for the workers. A large number of undertakings which have installed such dormitories in order to be sure of a regular labour supply have done so in a haphazard manner, quite insufficient to

provide for proper rest and personal cleanliness. Moreover, it sometimes happens that a two-shift system applies in the dormitory as in the workshop. Further, in small handicraft undertakings, the workers, and in particular the apprentices, often sleep in the workshop itself, a custom which is also to be found in small workshops in other Asiatic countries, for example, in the Chinese workshops in Indo-China.

Under these circumstances, the so-called panel system, under which doctors established in private practice treat insured persons at their surgery, or at the patient's home when the latter is incapacitated, would appear impracticable; no reasonably adequate care can be provided in overcrowded one-room tenements lacking air and light as well as sanitation, or in overcrowded dormitories; still less can it be provided if the worker can count on the use of his bed only for one half of the day or sleeps in a corner of the workshop. In view of the inadequate housing accommodation, hospitalisation of the urban population in the event of incapacitating illness would appear the only adequate solution. As to out-patient care, in view of the scarcity of doctors, their concentration in the wealthier districts, and the consequent inaccessibility of private surgeries to the industrial workers and other impecunious citizens in towns and cities, the provision of group practice at health centres would appear to offer considerable advantages, as pointed out by Professor Adarkar in his report on health insurance for industrial workers, already cited.

Professor Adarkar has also drawn attention to the danger of laxity in certifying incapacity for work under a panel system. In his opinion, a salaried service must be preferred from this standpoint, and it has the further advantages of facilitating group practice and providing an adequate income for young medical practitioners, who at present are handicapped by the poverty of the masses when establishing themselves in private practice. A salaried service based on well-organised health centres, staffed with nurses and other auxiliary staff to assist the doctors, and linked to hospitals providing specialist care, may be expected greatly to increase the efficacy of the doctor's work. Such co-

ordination and co-operation, it may be hoped, would more than compensate for the absence of commercial competition. "What is wanted", said the Minister of Health in the British House of Commons, when the National Health Service Bill was read a third time in July 1946, "is not a competitive, but an emulative spirit."

The Organisation of Health Services

Government Health Services.

Government health services providing medical care free of charge or subject to a means test, exist in many Asiatic towns or cities, although they are frequently inadequate to cope with a demand which, owing to a higher prevalence of disease in general, is potentially greater than in countries like Australia or New Zealand.

The organisation of medical care and general health care in various Asiatic countries has already been described earlier in this chapter. Large cities, such as Bombay and Calcutta, are equipped with Government hospitals comprising free out-patient departments available to the whole population, but the accommodation is, as yet, by no means sufficient to provide effectively for the total number of patients requiring hospitalisation or other care. In China, the health centre system of public medical care is planned mainly for the rural areas. Towns and cities have certain obligations to provide hospital care for those who are not able to afford it at their own expense. In Chungking, for instance, the health authorities maintain a number of clinics and medical units which provide medical care, undertake health examinations, provide first-aid, assist in cases of childbirth, and also conduct health education. At Canton City, the municipality owns two general hospitals, one hospital for infectious diseases, one for mental cases and one for women and children, and also maintains a health inspection institute, a dispensary, and district general health centres. The municipality moreover operates small first aid and immunisation stations in the dormitories of factories. The number of doctors in Canton practising western medicine is 1937; those practising Chinese medicine, 1,562. There

are also 680 midwives, 157 nurses, 284 dentists, 12 dental surgeons, 5 pharmacists, and 52 dispensers.

With the exception of wage earners, the urban population in Asiatic countries consists chiefly of tradesmen, artisans, and other classes of independent workers whose incomes may be assumed to be very low, although the presence of wealthy merchants and other well-to-do people in towns and cities tends to raise the average income in urban as compared with rural areas.

The reasons militating against social insurance or social assistance are therefore much the same as in the case of the rural population and include the scarcity of doctors in the poorer districts, as well as housing conditions. Another point in favour of a public health service, providing both medical and general health care and co-ordinated with environmental hygiene, is the fact that large agglomerations offer considerable facilities for the collective organisation of health services and environmental hygiene. Moreover, even where the standard of living is high, the mechanism of social insurance can only with difficulty be applied to independent workers and the self-employed.

The development of existing urban Government services on the lines of a hospital-health centre system would, for the great majority of the urban population, appear to present the most adequate programme, and permit of the integration of rural and urban health services in one well-organised, centrally controlled system. The financing of the medical care facilities in towns and cities by a special health tax on incomes above the subsistence level would be facilitated as a result of the accumulation of wealth in large cities.

Employers' Liability.

In some Asiatic countries, the employers of industrial wage earners are also liable to provide some form of medical care for their workers.

In Ceylon, for instance, the Factories Ordinance provides that facilities for rendering first aid and providing medical care of a preventive nature shall be maintained by the

employers in factories.[1] In shops the employers must provide for the workers' "comfort and health". The obligations of employers in Indo-China in respect of labourers under written contract—mainly agricultural—have already been referred to in this chapter. Employers of labourers without written contract in such industries as mining and railway construction are required to meet prescribed standards as to the food and lodging provided, safety measures, isolation of the sick and medical care facilities. Larger establishments in Tonkin must provide a medical station staffed by a medical attendant, an ambulance service with a medical attendant, or a resident doctor. The cost of hospitalisation is met by the employer.

The effectiveness of such regulations evidently depends on the extent of the supervision exercised by the health authorities. In any event, the responsibility of providing medical care should not be placed on the employer alone; it has been recognised, internationally, as a collective liability of society.

Social Insurance for Wage Earners.

In the West, and more particularly in Europe, medical care for wage earners has been provided largely through the agency of social insurance schemes, which were grafted on existing private medical practice and made use of public and voluntary hospitals for the hospitalisation of insured persons and their dependants. Social insurance is a stage in the evolution from poor relief *via* social assistance to a system under which the beneficiary emerges from the status of a recipient of charity or a pauper subjected to a means test and becomes a citizen entitled to medical care as of right. This evolution, as regards medical care, seems to be leading to a concept transcending both the concept of social assistance and that of social insurance, namely, the concept of a public medical care service, available to all without a means test or contribution conditions, and financed from general revenue or by a special tax on income, com-

[1] This provision has not been brought into force because of the absence of a suitable technical officer.

parable to the public service of education as it is now conceived in enlightened countries.

Public medical care services have been established in Australia and New Zealand, and a complete public service has recently been introduced in Great Britain. The introduction of a public health service has been approved in Sweden and is being planned in Czechoslovakia, where it would supersede the existing social insurance medical care service for wage earners. The Irish Government also intends to initiate a policy that would put an end to the dependence of both preventive and curative health services on the public assistance system Mothers and children will be the first to receive free medical care without a means test.

In Asiatic countries, with their predominantly rural population, the stage of poor relief or social assistance has, in a number of cases, been bypassed, owing largely to the inability of the masses, both rural and urban, to pay for medical care, and the necessity to proceed by way of Government aid rather than self-help. There, medical care is provided as a public service. On the other hand, sickness insurance providing benefits in cash and in kind is almost non-existent at present. The salt miners' insurance scheme in China, the sickness funds in India, and the so-called welfare funds in those two countries have been described in Chapter III. In China, these welfare funds are more in the nature of social insurance, being financed by contributions from or taxes on employers and workers; in India, the funds for the coal and mica mines are supported by a tax on coal and coke or mica and are more in the nature of public services, being administered by the Central Government, which may also make grants to such funds. Plans are at present under consideration to introduce social insurance for all factory workers, both in China and in India.

An interesting case of the organisation of medical care on a co-operative basis is that of the Shanghai Co-operative Industrial Hygiene Centre, which was organised in 1941 to provide health care for workers of undertakings too small to be expected to open a dispensary of their own. The principle of the scheme is to set up a joint dispensary for a

group of member factories which are situated about 10 to 15 minutes' walk apart. By 1944 the Centre had 476 member factories with a total of 10,000 workers, and it runs 5 dispensaries and a small hospital.

If medical care for wage earners were to be provided by means of social insurance, part of the contribution raised could be used to make available to insured persons and to their dependants special medical facilities, either separate and owned by the insurance institution, or, preferably, forming part of the public medical care service and administered under the supervision of the health authorities. This method would have the advantage of hastening the introduction of sickness cash benefit insurance, of giving insured persons better medical care than they would otherwise obtain in the near future, and of establishing a closer link between cash benefit insurance and the medical care service. Great care would have to be taken to preserve intact the medical facilities at present maintained by employers where these are of a high standard, as is not infrequently the case in Asiatic countries. Provision might be made for employers to continue the management of their own service under the insurance scheme, in return for a payment from the insurance fund.

It may, however, be questioned whether, in the given circumstances, social insurance would be the appropriate vehicle for providing industrial wage earners with medical care. They represent a very small percentage of the total population and only a fraction of the urban population; for the others, medical care would have to be provided in the form of a public service co-ordinated or integrated with the provision of general health care and environmental hygiene. To single out wage earners for social insurance would be contrary to the basic principles of a public service: equality of treatment and universal availability. Further, the level of wages is, in general, low and many wage earners' incomes would be found to be below the subsistence level; contributions on their behalf would, accordingly, have to be paid either by the public authorities or by their employers. The social service would therefore be financed

from the same sources as the public medical care service, namely, the incomes of employers, the incomes of wage earners which exceed the subsistence level, and the general revenue. In other words, under a social insurance medical care service for wage earners which is grafted on, or parallel to, a public medical care service for the rest of the population, employers and wage earners with taxable incomes would be paying insurance contributions on pay-rolls instead of the health tax on income outlined above[1], in addition to contributing, through general income tax or otherwise by taxation, to the general revenue, part of which would go to the financing of the public health service. As contributions on pay-rolls tend to become—from the standpoint of the employer—part of the wage, and thus of the cost of production, the ultimate cost would fall on the consumer, without the equity of distribution inherent in the income tax system.

Moreover, any special arrangements for providing insured persons with better medical care would tend to throw out of gear the normal development of the public service, and workers moving in and out of insured employment would be entitled to such special care only during their periods of insurance, when they would obtain their medical care from the special facilities placed at the disposal of the insurance fund, and would be thrown back on the general service when out of insurance. This method would also result in discrimination between different groups of beneficiaries of the public medical care service. Such a state of affairs exists at present in Chile, where the public hospital administration provides free care to all citizens, while the social insurance funds have their own clinics, but avail themselves of the facilities owned by the hospital administration for the hospitalisation of insured persons, in return for special payment. Insured patients accordingly receive preferential treatment in hospitals. It may be mentioned that leading experts in that country favour the eventual amalgamation of all medical care services in a public service providing adequate care for the whole population.

[1] See pp. 104—106.

Summary of Proposals

A Public Medical Care Service

A brief study of the structure of population, health conditions and health facilities, the existing provisions for health, and the tendencies prevalent among experts, as well as financial considerations, would appear to favour the establishment of a public medical care service, integrated or closely co-ordinated with the provision of general health care and environmental hygiene, rather than of a system of social insurance. The alternative of a social insurance service presupposes a standard of living under which a majority of the population enjoy an income, largely in cash, above the subsistence level; an ample supply and adequate distribution of doctors already established in practice; and, so far as industrial workers are concerned, stability of employment. None of these conditions are fulfilled in the majority of Asiatic countries. A means test, on the other hand, would appear redundant in view of the low standard of living of the majority both of the rural and of the urban population, which leaves little doubt as to their inability to pay for medical care. The need for health protection, moreover, is universal, and calls for a form of organisation embracing the whole population, and the removal of all barriers that tend to withhold care from those who need it.

The wealthier classes, including more particularly employers, merchants and landowners, may be called upon to make the major contribution to the cost of the health service, not only by way of ordinary taxation but in the form of a health tax specially earmarked for medical care. They will be entitled to avail themselves of the medical care service and will actually do so once the standard has been raised to such a high level of efficiency as to make private practice and nursing facilities redundant. At the same time, all self-employed persons, whether farmers, wage earners, shopkeepers, artisans or others, whose income in kind or in cash is in excess of the subsistence level could be called upon to contribute a health tax towards the cost of a medical care service. The proceeds of this health tax would be used for the improvement and extension of a

medical care service available free of charge to all residents. In addition, a prescribed part of the general revenues of central, provincial, State and local authorities, increasingly large as the national income rises, would be set aside for financing the central services, such as general hospitals, health centres for specialist treatment, and special institutions for infectious diseases, tuberculosis and mental cases, and to meet the expenses of central administration.

Some idea of the magnitude of the proceeds of a health tax may be gained from estimates of the distribution, according to ownership, of the rural area in India. In 1937-38, 25 per cent. of the total area under cultivation was owned by landlords ("zamindars"), 39 per cent. partly by landlords and partly by village communities, and 36 per cent. by peasants. It should be noted, however, that a very large number of persons not cultivating the land derive their income therefrom. The intermediaries between landlord and cultivator are very numerous, sometimes more than 50, and rackrenting prevails in some areas to such an extent as virtually to obliterate the distinction between the cultivating tenant and the landless labourer. Care should presumably be taken to tax, first of all, those who derive income without themselves cultivating the land.

The health service would be based on central hospitals equipped with complete out-patient departments providing all kinds of specialist care, and complemented by smaller hospitals at the more important population centres, suitably distributed according to density of population. Concentric rings of out-patient clinics located at health centres providing also general health care, and distributed over the country according to density of villages, would send cases requiring specialist care or hospitalisation to the nearest hospital-health centre. Moreover, ambulant specialist services could, where required, visit out-patient clinics in villages and small towns at regular intervals. For sparsely settled areas, flying doctor services, providing first aid, general practitioner care, and general health care, such as inoculation, could be organised much on the lines of the Australian Flying Doctor Service. Every village should eventually

be visited periodically by doctors and have reasonable access to an out-patient clinic combined with a health centre and to specialist treatment at the larger towns. So far as possible, a child welfare centre giving advice and help to expectant and nursing mothers should be set up in each village.

This might be the long-term health programme in Asiatic countries. However, in view of the relatively low income both of the urban and of the rural population, the establishment, improvement and extension of a public medical and general health care service will probably be very slow. It might, therefore, be advisable to speed up the process of improving the medical care facilities by concentrating efforts on certain areas where funds could be raised more readily than is generally the case. Such areas might include farming districts with a relatively high output of agricultural produce per head of population and industrial areas, or towns or cities whose inhabitants would be willing to make a special effort. The health tax suggested above on incomes considerably in excess of the subsistence level would first be used for the construction or extension and the equipment of health centres with out-patient clinics and ambulance services in the area where it is raised. These health facilities would be owned by and would form part of the public medical care service of the State or province in which the area is situated, and their administration would be in the hands of the health authorities. They would be available to all residents of the area concerned, whether or not they were liable to the health tax. Health boards representing the local beneficiaries might be formed to advise and assist the local health officers employed by the central, provincial, or State health authorities, as the case may be, in the local administration of the service.

In the case of industrial workers who are also covered by cash benefit insurance schemes, the social worker or other officer—preferably a nurse—of the health service could be entrusted with the task of visiting at their home and helping incapacitated patients who are not hospitalised, and incidentally of keeping a check on malingering. Health work at village health centres could be combined with other orga-

nised work for the improvement of rural conditions, through the teaching of more rational farming methods, the better selection of seeds, the introduction of subsidiary cottage industries, the instruction of women in handicrafts, and like measures.

In this way, while a universal health service providing medical and general health care would be introduced and gradually extended over the whole country, a medical care service of a higher standard than would otherwise be available could immediately be developed in those areas where a health tax could profitably be levied without delay. A small part of this tax would evidently have to be set aside, not for the improvement of local services, but as a contribution towards the cost of administration by the health authorities and also to secure, for the area in question, specialist care and hospitalisation at larger hospitals and medical centres outside the area.

If this alternative were adopted, the introduction of sickness benefit insurance for wage earners would have to be so timed as to coincide with the attainment of an adequate standard of medical care in the areas where the wage earners reside. Without such adequate medical care, as pointed out in Chapter V, sickness insurance for cash benefits would be impracticable.

Social Insurance

It may be argued that the development of a public medical care service on the lines suggested in the preceding paragraphs will be so slow as to delay unduly the introduction of sickness-cash benefit insurance for wage earners, and that the possibility of expediting the provision of adequate medical care for wage earners by the method of social insurance should therefore be considered. Insurance contributions could, if this alternative were adopted, be partly applied to the provision of special medical facilities for insured wage earners within the public medical care service, pending the development of the latter. Clinics could be built near the places of work or residence of wage earners and made available only to insured persons and their families.

and accommodation of a better class than that at present provided in public wards could be made available to insured persons at public hospitals, conceivably by the construction of special wings, and in return for payment by the insurance fund.

The advantages and disadvantages of such a development have been discussed in the preceding section of this Chapter. If the achievement of a satisfactory and well-balanced medical care service for the whole population is deemed a primary aim of national social policy, the coverage of wage earners by the general public health service, without a subsidiary social insurance scheme providing benefits in kind, would appear to be the more desirable solution.

CHAPTER VII

LIST OF POINTS FOR DISCUSSION

The following list, which is not intended to be exhaustive, includes only those points upon which discussion appears to be necessary in order to enable the main issues encountered in the planning of a social security programme to be clarified. It is assumed that the general principles of the Income Security and Medical Care Recommendations, 1944, are accepted as a final objective.

Income Security

1. Desirability and feasibility of a separate income security programme for peasants, providing for :

(*a*) use of co-operative societies as social insurance agencies;
(*b*) group life insurance and group accident insurance covering serious disablement and death;
(*c*) experimentation with crop and livestock insurance which would cover the gravest risks to the peasant's income security and remove the main cause of his indebtedness.

2. Desirability of gradually introducing an income security system for employed persons, on the basis of social insurance, in which regard would be had to the following principles:

(*a*) adoption from the outset of an integral long-term plan of social insurance to be fulfilled by stages;
(*b*) insurance of all employed persons in the area where the system applies, subject only to the provisional exception of workers in small and unstable undertakings;
(*c*) benefits aimed at affording at least a minimum of subsistence;
(*d*) provisions governing contribution and benefit rates and benefit rights made as simple as possible;

(*e*) provision for merging the rates of employment injury benefits with those of the corresponding benefits of sickness and pension insurance.

3. Consideration of the suggested necessary conditions for the introduction of benefits for the several risks:

(*a*) basic old-age and survivors' pensions can be introduced immediately for an urban population comprising employed persons, employers, and self-employed, provided that the great majority of the insured population will spend their working lives within the area of administration and provided that a substantial subsidy from general taxation can be afforded;

(*b*) benefits in case of sickness, maternity, and employment injury can be effectively administered for all persons employed in industrial and commercial undertakings and on plantations, where the employers are large and stable enough for it to be practicable to collect contributions, provided that adequate medical facilities exist for the treatment of beneficiaries;

(*c*) benefits in case of invalidity can be effectively administered only for persons who are insured for sickness benefit and for old-age and survivors' pensions;

(*d*) benefits in case of unemployment can be effectively administered for a population that is sufficiently large, stable, and dense and that is employed in well-diversified industry and commerce, provided that an experienced employment service is already in operation.

4. Desirability and feasibility of establishing a small experimental scheme of social insurance covering the risks of sickness, maternity, and employment injury in order to:

(*a*) develop suitable administrative machinery and procedures and to train personnel;

(*b*) develop co-ordination with the medical care service;

(*c*) investigate the morbidity of the insured population and ascertain the quantity and quality of medical facilities required for adequate treatment;

(*d*) work out suitable rates of contributions and benefits.

Medical Care

5. Desirability of providing medical care for the whole population on the basis of a public service, without contribution condition or means test, rather than through social insurance or social assistance, in view of:

(*a*) the predominantly rural character of Asiatic countries and their village economy;
(*b*) the absence, in many areas or communities, of a money economy;
(*c*) the low standard of living of the population in general;
(*d*) the general need for an extension of medical care facilities; and
(*e*) the prevalence of preventable disease.

6. Desirability and feasibility of integrating the public medical care service with general health care services and, to some extent, with environmental hygiene in one complete health service, with a view to rendering the medical care service more effective by strengthening and extending preventive measures and environmental hygiene.

7. Feasibility of financing the public medical care service by a special tax on incomes exceeding the subsistence level, with a view to accelerating and facilitating the extension of medical care services by adding the proceeds of the special tax to the funds coming from general revenue.

8. Desirability of first introducing the special tax in areas where, owing to high agricultural output or a high average level of income, the proceeds of the tax would be appreciable, and of using these proceeds to develop medical care facilities in that particular area, taking into consideration the fact that the raising of the standard of medical care in the whole country may progress slowly.

9. Desirability of providing, for wage earners in urban areas, special medical care facilities by means of social insurance contributions.

10. Desirability of vesting the ownership and administration of such special medical care facilities for wage earners, if any, in the health authorities administering the public medical care service for the whole population or, alternatively, of vesting their ownership and administration in the wage earners' insurance institution.

11. Feasibility of organising the medical care service on the basis of hospital-health centres providing all kinds of in- and out-patient care, and complemented by local hospitals and outposts for general practitioner care and auxiliary services.

12. Feasibility of locally co-ordinating medical care and general health care, such as maternity and infant care, vaccination, examination of school children and the like, by establishing common centres as headquarters for all or most health services, or alternatively, by establishing

medical care centres in proximity to those for general health care.

13. Feasibility of organising travelling clinics in motor vans or aircraft, or other mobile hospitals providing first aid, dental care, general examination, maternity and child care and possibly specialist care and temporary hospital accommodation.

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